Computerized Patient Record System (CPRS)

User Guide

GUI version

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Introduction

What is CPRS?

The Computerized Patient Record System (CPRS) is a Veterans Health Information Systems and Technology Architecture (VISTA) computer application. CPRS enables you to enter, review, and continuously update all information connected with any patient. With CPRS, you can order lab tests, medications, diets, radiology tests and procedures, record a patient's allergies or adverse reactions to medications, request and track consults, enter progress notes, diagnoses, and treatments for each encounter, and enter discharge summaries.

CPRS not only allows you to keep comprehensive patient records, it enables you to review and analyze the data gathered on any patient in a way that directly supports clinical decision-making.

Using CPRS Documentation

Related Manuals

Computerized Patient Record System Installation Guide

Computerized Patient Record System Setup Guide

Computerized Patient Record System Technical Manual

Computerized Patient Record System Online Help

Clinical Reminders Manager Manual

Clinical Reminders Clinician Guide

Text Integration Utility (TIU) Clinical Coordinator and User Manual

Consult/Request Tracking User Manual

World Wide Web

CPRS documentation is also available on the **V*ISTA*** Intranet. The Intranet version will be constantly updated, and thus might contain more current information than this print version.

Intranet address: http://vista.med.va.gov/cprs/

Online Help

Instructions, procedures, and other information are available from within the CPRS program. The online help that is available in CPRS follows many of the standards and conventions of the Help feature in other Windows programs. You may access Help by click on **Help | Contents** from the menu bar or by pressing the F1 key while you have any CPRS dialog open. Much of the information in this User Manual is also in the Help.

CPRS Graphical User Interface (GUI)

CPRS was designed to run in both the Microsoft Windows operating environment (usually referred to simply as Windows) and on terminals. The terminal or text-based version of CPRS (also known as the List Manager version) is **not** described in this manual. This manual describes the Windows version of CPRS.

The Organization of this Manual

This manual is organized in the way most people will see the CPRS GUI product. It begins with how to log on to the system and then how to select a patient. CPRS presents the patient's record as a tabbed chart. This user manual explains the main features that are available on each of the tabs. It also explains, in detail, each tab and some of the dialogs that are available from the tabs.

We hope this organization will help the user understand the basic layout of the CPRS GUI application and then give the user more information about the specific tasks you will perform.

Signing on to CPRS

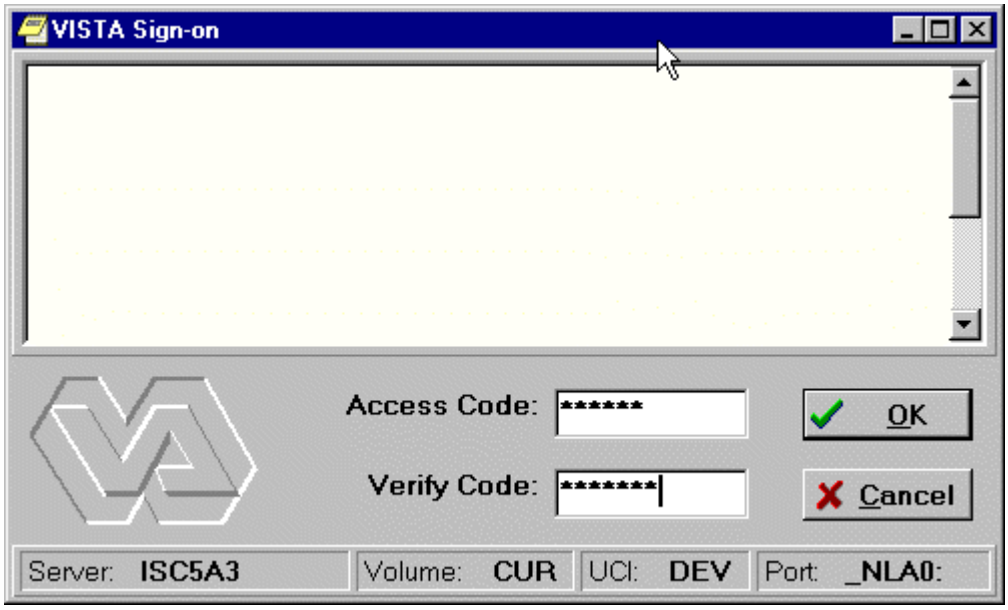
Once CPRS has been installed on your workstation and you have been issued an Access Code and a Verify Code, you can sign onto CPRS. You will need both an Access Code and a Verify Code to gain access to CPRS.

To start CPRS, double-click on the CPRS icon on your Desktop. The VISTA logo window opens for a few moments and is followed by the VISTA Sign-on dialog.

If the Connect To dialog appears, click on the down-arrow, select the appropriate account (if more than one exists), and click **OK**.

Type the Access Code into the Access Code field and press the Tab key. Then, type the Verify Code into the Verify Code field and press the Enter key or click on OK.

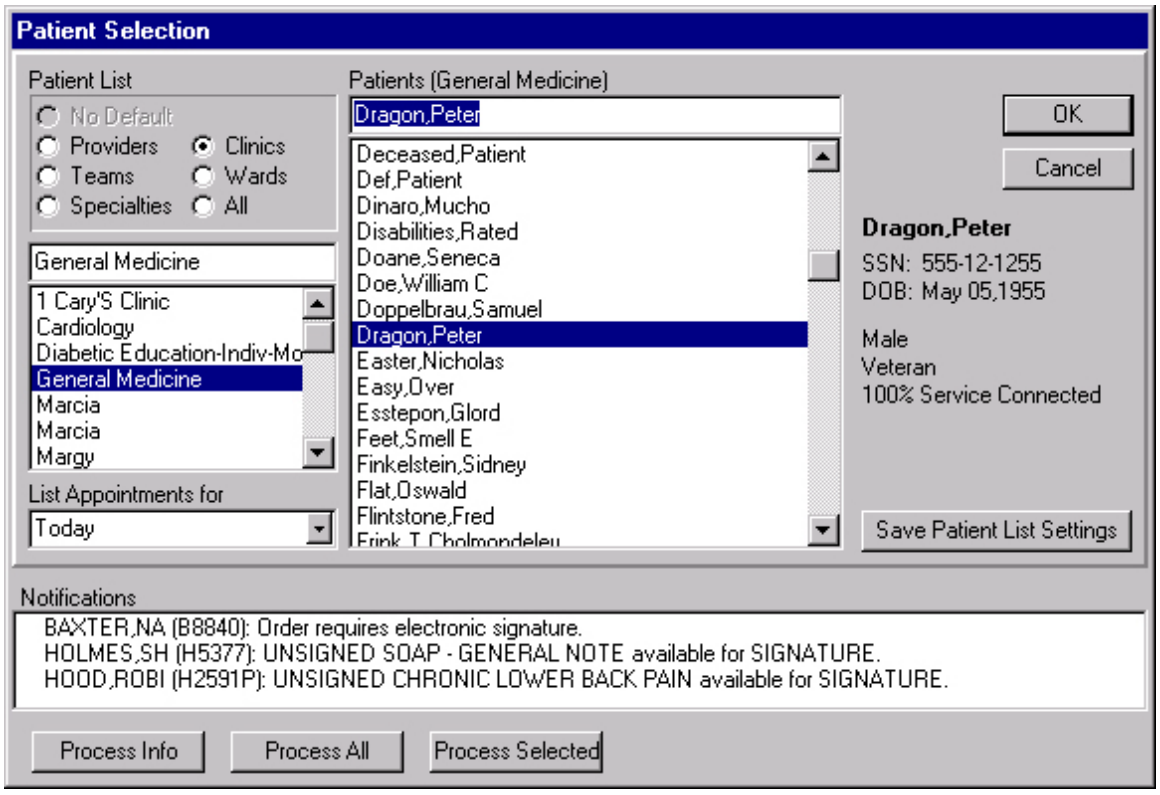
Shortcut: You can also type the Access Code, followed by a semicolon, followed by the Verify Code and then press the Enter key or click OK.



Once you have successfully entered the access and verify codes, CPRS opens with an empty patient Cover Sheet and the Select Patient dialog.

Selecting a Patient

After you log in to CPRS, the Patient Selection screen, shown below, is the first thing to appear.



To select a patient, you can either type in part or all of their name or Social Security number, or you can use the mouse to select a clinic, ward, or specialty and then click on the name.

If you type in the patient information, you can enter one of the following:

- Part or all of the patient's name (e.g., "smit" or "smith, joe")
- The first letter of the patient's last name and the last four digit of the patient's Social Security number (s4444)
- The full Social Security number with or without dashes (123-44-4444 or 123444444); or the full Social Security number with "P" as the last character (123-44-4444p, or 123444444p).

When you stop typing, CPRS will use what you entered to search the patient list and bring up that part of the patient list, highlight a possible match, and display the patient's demographic information under the Cancel button.

If you use the mouse, you can select from a comprehensive list of patients (the All selection) or select a patient list category, and patient list. (Setting one list as your default selection is discussed later in this manual.)

When you select a specific list for a provider, team, specialty, clinic, or ward, CPRS will display the associated patients in the Patients list box, followed by a line, and then the comprehensive patient list. You can then scroll to find the name.

Your Clinical Coordinator will usually create the lists for the teams, wards, and so on.

Patient Selection Messages

When you select a patient record to open, you may receive one or more of the following messages:

- **Means Test Required –** This message tells you that the patient's ability to pay for medical services must be evaluated.
- **Legacy Data Available –** This message would be found only at a consolidated facility. It informs you that the selected patient has data from the system you used before your site was consolidated that is not being displayed and that you may want to access.
- **Sensitive Patient Record –** This indicates that the record is sensitive and must only be viewed by those with appropriate authority and need.
- **Deceased Patient –** This message tells you that the patient you have selected is deceased and asks if you would like to view the record anyway.
- **Patient with Similar Name or Social Security Number –** This message appears if you enter only part of a patient's name or the last four digits of the Social Security number. If CPRS finds more than one match for what you have entered, this message appears and CPRS presents the possible matches so that you can select the right one.

Patient Selection Lists

You or your clinical coordinator can create patient or team lists for your convenience in reviewing patient charts, ordering, signing orders and notes, and so on. You manage patient lists through the List Manager interface, the character-based version of CPRS. You or your clinical coordinator can set up lists for wards, clinics, teams, and so forth.

- Quickly locate your patients without going through all the patients in the list.
- Create lists for teams of clinicians who can sign or cosign for each other.
- Tie notifications to teams, ensuring that all team members receive necessary information about a patient.

Setting a Default Patient Selection List

To make it easier for you to locate your patients, CPRS enables you to set a default patient list. This is the list that will appear when you launch CPRS. For example, if you work in a specific ward, you can set the default patient list to be the list for that ward.

To set the default list, use these steps:

1. If you are just opening CPRS, skip to step 2. Otherwise, select **File | Select New Patient...**.
2. In the Patient Selection screen, select the category in which you want to search for a patient's record by clicking the option button in front of the category (Default, Providers, Teams, Specialties, Clinics, Wards, or All).
3. In the list box below the option button, click the item that narrows the search further (such as a specific ward).

If you select something other than All, CPRS sorts the patient list and divides the list into two parts: Above the line are the names for the category and item you selected; below is a comprehensive list.

4. To save the patient list you have chosen, click **Save Patient List Settings**.

Notifications

Notifications are messages that provide information or prompt you to act on a clinical event. Clinical events, such as a critical lab value or a change in orders trigger a notification to be sent to all recipients identified by the triggering package (Lab, CPRS, Radiology, and so on). The notifications are located on the bottom of the Patient Selection screen.

CPRS places an "I" before "information-only" notifications. Once you view (process) information-only notifications, CPRS deletes them. When you process notifications that require an action, such as signing an order, CPRS brings up the chart tab and the specific item (such as a note requiring a signature) that you need to see.

Note: When CPRS is installed, all notifications are disabled. IRM staff and clinical coordinators set site parameters through the Notifications Management Menus in the List Manager version of CPRS that enable specific notifications. Notifications are initially sent to all users. Users can then disable unwanted notifications through List Manager's Personal Preferences.

Notifications are retained for a predetermined amount of time (up to 30 days), after which they may be sent to another destination, such as your MailMan surrogate or your supervisor. Confer with your clinical coordinator to establish and set up these options. You can also confer with your clinical coordinator to select what types of notifications you will receive. Some notifications are mandatory, however, and cannot be disabled.

Clinical Notifications are displayed on the bottom of the Patient Selection screen when you log in to CPRS. Only notifications for *your* patients are shown.

Processing Notifications

CPRS provides you with flexibility in choosing which notifications you will process. You have three choices: Process Info, Process All, and Process Selected.

To process notifications, use these steps:

1. Bring up the Patient Selection screen, either by launching CPRS or if you are already running CPRS, selecting **File | Select New Patient**.
2. Decide which notifications to process.
   - All Information notifications (items preceded by an I.), click Process Info.
   - All notifications, click **Process All**.
   - Specific notifications, highlight one or more notifications, and then click Process Selected. You can also double-click individual notifications.

Note: To select a number of notifications in a row, click the first item, hold down the Shift key, and click the last item. All items in the range will be selected. To select multiple items that are not in a row, click one, hold down the Control key, and click the other specific notifications.

3. Process the notification by completing the necessary task, such as signing an overdue order or viewing information notifications.
4. Click the **Next** button on the status bar.
5. Process the remaining notifications using steps 3 and 4.
6. When finished, you may select a new patient (**File | Select New Patient…**) or exit CPRS (**File | Exit**).

Opening Another Patient Record

From within one patient's record, you can easily switch to another patient's record.

1. Click on **File | Select New Patient...**

Note: If you have created or changed any orders or documents that are unsigned, a pop up window will appears and request that you review and/or sign the additions or changes.

2. In the Patient Selection screen, type a) the patient's Social Security number, b) part off the patient's name, or c) the patient's entire name. CPRS will try to match what you enter to a patient record. The highlighted patient's name and other information will appear below the Cancel button.

   -or-

   Click on a Patient List category (Providers, Teams, Specialties, Clinics, or Wards). In the list box that appears, click on the desired item (such as a specific ward). CPRS resorts the patients and displays only those meeting the selected Patient list criteria. In the Patients field, locate the desired patient's name (scrolling if necessary) and click it once. The patient's name and other information will appear below the Cancel button unless this record is marked as sensitive.

3. Verify that the desired patient is highlighted. If the correct patient is highlighted, click **OK**. If the desired patient is not highlighted, scroll through the patient list to find the correct patient, highlight the name, and then click **OK** or double-click on the desired patient name.

Features Available from Any Tab

In the CPRS GUI, the tabs are intended to mimic the paper chart. Chart tabs divide functionality. Even the menu items on the View and Action menus change depending on which tab is selected.

However some features are available regardless of which tab is active:

- Patient Inquiry
- Current Activities (Encounter Provider and Location)
- Primary Care
- Remote Data Views
- Reminders
- Postings (CWAD)

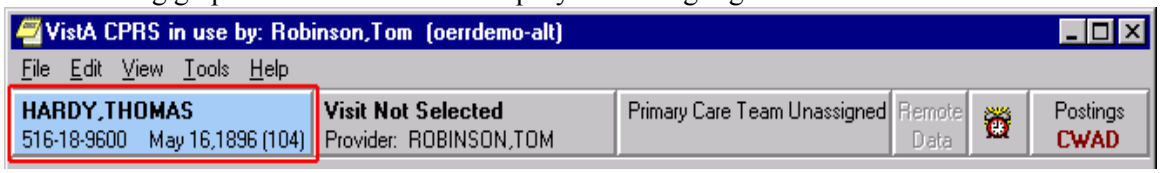
These buttons are located on the top of the chart below the menu bar as shown in the graphic below.

All of these items have two purposes. They provide you with immediate feedback about the patient or the patient's care, and they provide additional information when clicked.

Each of these items will be discussed briefly to help you understand what they do and how they can be useful to you.

Patient Inquiry

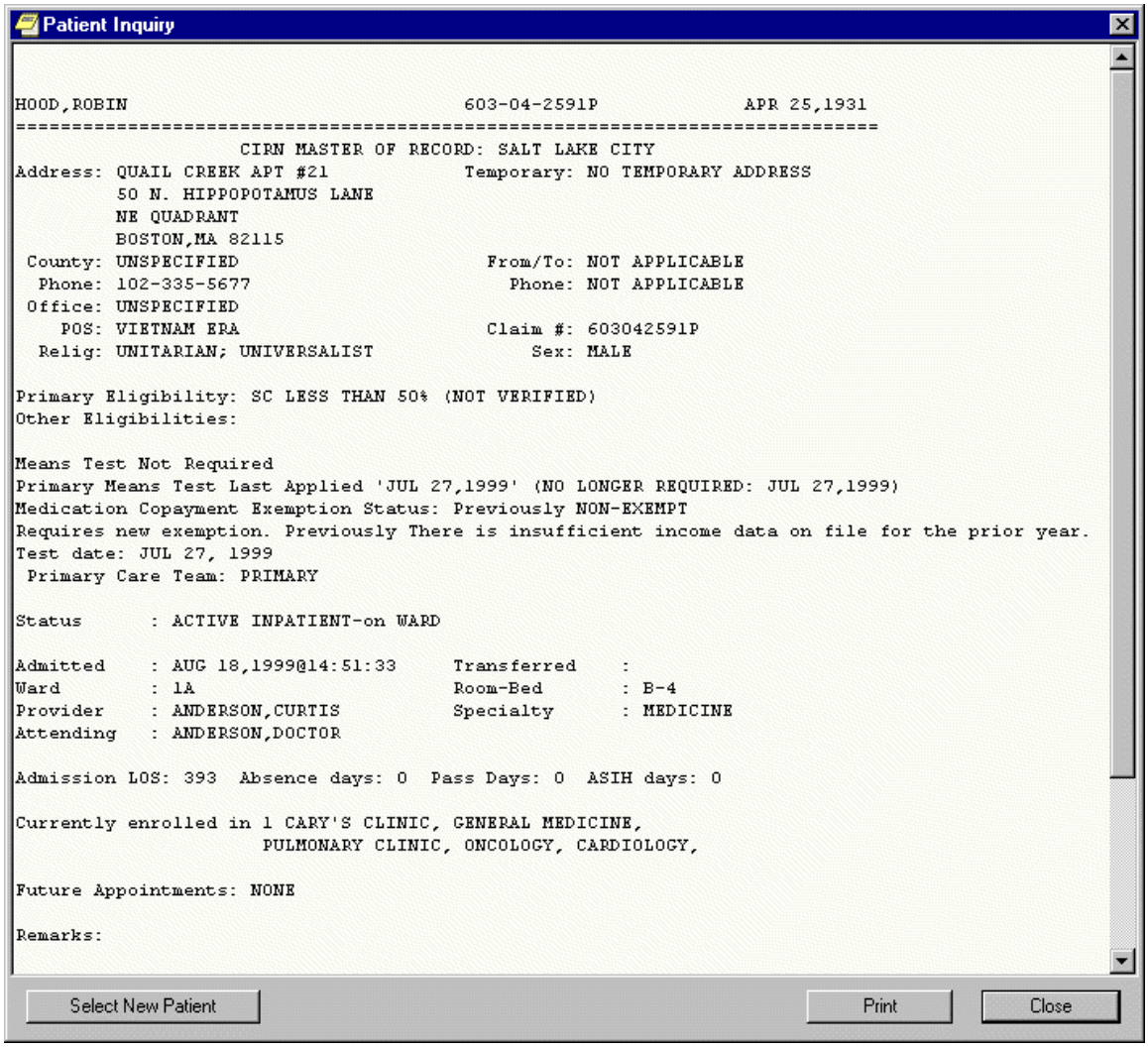
The Patient Inquiry button is on the left of the chart directly below the menu bar. The following graphic shows the Patient Inquiry button highlighted.



It displays the following:

- Patient name
- Social Security number (or identification number if assigned by the site)
- Date of birth
- Age

If you click on the button, you get more detailed information including mailing address, telephone numbers, admission information and so on.



While in the detailed display, you can select a new patient, print the detailed display, or close the detailed display.

Encounter Identification

CPRS has two kinds of encounter information: visit information and encounter form data. Encounter form data is explained later in this manual.

For each visit (or telephone call) with a patient, you need to enter the provider, location, date, and time. CPRS requires this information before you can place orders, write notes, add to the problem list, and so on.

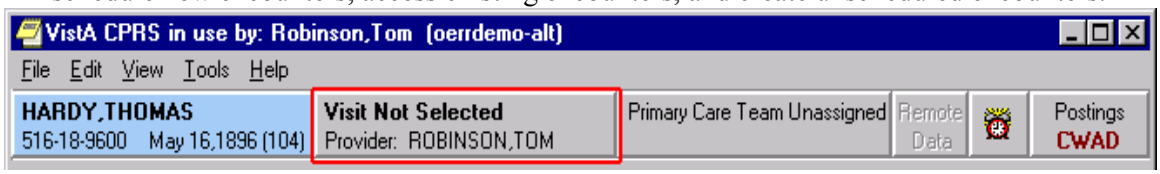
To receive workload credit, you must enter the encounter form data, including the following information, for each encounter:

- Service connection
- Provider name
- Location
- Date
- Diagnosis

- Procedure

Visit / Encounter Information

CPRS shows the encounter provider and location for the visit on the Visit Encounter button. You can access this feature from any chart tab. This procedure can be used to schedule new encounters, access existing encounters, and create unscheduled encounters.



Entering Encounter Provider and Location

If a provider or location has not been assigned, CPRS will prompt you for this information when you try to enter progress notes, create orders, and perform other tasks to track where the patient was seen and by whom. You enter other encounter information such as diagnoses, procedures, patient education, and so on when creating a progress note. This information is discussed later in this manual.

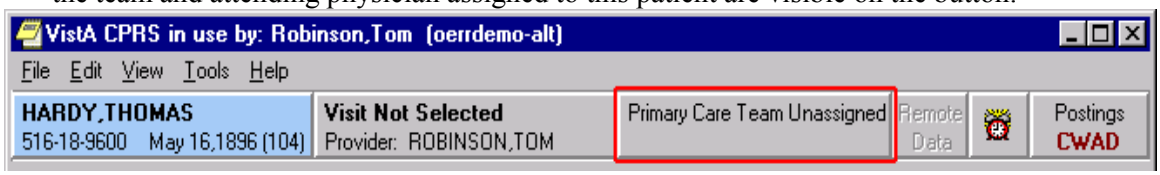
To enter or change the Encounter provider, follow the steps below:

1. If you are already in the Provider / Encounter dialog skip to step 2. Otherwise, from any chart tab, click the **Provider / Encounter** box located in the top center portion of the dialog.
2. Locate and click the provider for this encounter in the list box.
3. Click the tab of the correct encounter category for this visit:
   - Clinic Appointments
   - Hospital Admissions
   - New Visit
4. Select a location for the visit from the choices in the list box.
5. If you selected a Clinic Appointment or Hospital Admission, skip to step 7. If you are creating a New Visit, enter the date and time of the visit (the default is NOW).
6. Click a visit category from the available options (such as, Historical) and click **OK**.
7. When you have the correct provider and location, click **OK**.

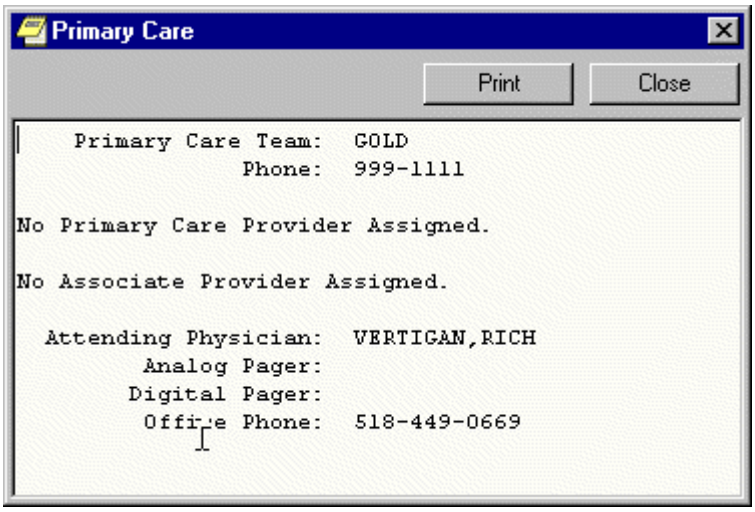
For more information and instructions on entering more encounter form data, refer to the Notes section of this manual.

Primary Care Information

To the immediate right of the Visit Encounter button is the Primary Care button, which allows the user to make an inquiry about the primary care team for a patient. If assigned, the team and attending physician assigned to this patient are visible on the button.



For a detailed display, click the button.



Detailed information might include:

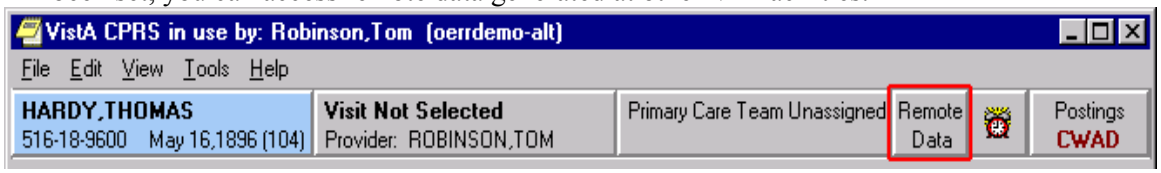
- Primary Care team assigned
- Primary Care Provider assigned
- Associate Provider assigned
- The attending physician's name and contact information

Click on **Print** to create a hard copy of the data. The patient's name and other vital identification information will appear at the top of the report although they do not appear on the dialog. When finished with the detailed display, click **Close**.

Remote Data

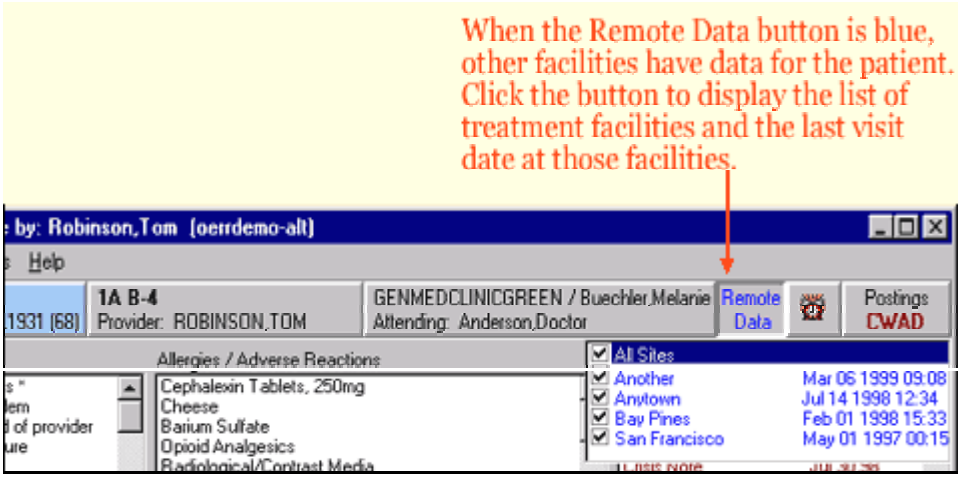
Note: To view remote patient data through CPRS, the proper patches must be installed. For more information, please contact you Clinical Application Coordinator (CAC).

With all the proper patches installed, you can now view remote patient data through CPRS. You facility must have Master Patient Index/Patient Demographics (MPI/PD) and several other patches installed. Once these are in place and the proper parameters have been set, you can access remote data generated at other VA facilities.



How Do I Know a Patient Has Remote Medical Data?

As part of opening a patient record, CPRS checks in the Treating Specialty file to see if the selected patient has been seen in other VA facilities. If the patient has remote data, the words on the Remote Data button turn blue as shown in the image below. If there is no remote data for the selected patient, the letters are gray.



What Does the List of Sites Represent?

If you click on the Remote Data button, the field displays a list of sites where the patient has been seen. This list is based on either:

- Sites that have been specifically designated for your facility to access. These sites are assigned in a parameter that your Clinical Applications Coordinator (CAC) can set up.
- All sites where the patient has been seen once MPI/PD has been installed at all sites

How Will the Remote Data Be Viewed?

Viewing remote data is a two-step process. First, you select which remotes sites from which you want to see data, and then you select the specific information you want to view, such as lab tests or health summary components.

On the Labs tab and the Reports tab, each site you select will have a separate tab for its data. Using the above graphic as an example, you would see five tabs on the Reports tab: Local, Another, Anytown, Bay Pines, and San Francisco.

You would then go to the Labs or Reports tab, select the reports or lab you want to view and a date range. After which, CPRS will attempt to retrieve those reports. You would then click on each tab to see the report from that site. While it is attempting to retrieve the data, the message "Transmission in Progress: " is displayed until the data is retrieved.

What Kind of Data Can I View?

Currently with CPRS, you can view some lab and health summary components. There are limitations to what you can view.

- You can view any lab results that do not require input other than a date range.
- You can view health summary components that have the same name on both the local and the remote site. You can therefore exchange national Health Summaries, but locally defined components may not be available unless the other site also has a component with the same name.

Viewing Remote Data

There are three steps to viewing remote patient data:

- Verify that the patient has remote data.
- Choose the site from which you want to view data.
- Select the Lab Report or Health Summary component you want to view.

To view a patient's remote data, use these steps:

1. After opening the patient's record, see if the text on the Remote Data button is blue. If the text is blue, the patient has remote data.
2. Click the tab you want remote data from (e.g., Labs or Reports).
3. Click the **Remote Data** button to display a list of sites that have remote data for the selected patient.

Note: Currently, you must select which sites you want to see data from first. Then you choose which Health Summary or Lab to view.

4. Select the sites you want to view remote data from by clicking the checkbox in front of the site name.
5. Select from the available Health Summaries or Lab what data you would like to see.

   It may take a few minutes to retrieve the data. While CPRS retrieves the data, the message "Transmission in Progress" will be displayed on the tab.

Note: For remote data, the local and remote sites must use the same names for the data they want. Nationally released Health Summaries will work. Another restriction is that only lab tests that do not prompt for anything other than a date will work.

6. Click the tab of the remote site to view data from that remote site.

The Reminders Button

The CPRS GUI includes functionality from Clinical Reminders. Reminders are used to aid physicians in performing tasks to fulfill Clinical Practice Guidelines and periodic procedures or education as needed for veteran patients.

Note: For more detailed information on Reminders, refer to the *Clinical Reminders Manager Manual* and the *Clinical Reminders Clinician Guide.*

The Reminders button highlighted in red below shows you at a glance whether the patient has reminders that are due.

By observing the color and design of the icon on the Reminders button, the user receives immediate feedback on the most important type of Reminders available for the selected patient. Clinical Coordinators can set Reminders to be evaluated when you enter the chart or they can set it to evaluate the Reminders only after you click the Reminders button or the Reminders drawer.

The following icons could be visible on the Reminders button:

Due: The patient meets all the conditions for the reminder and the appropriate amount of time has elapsed.

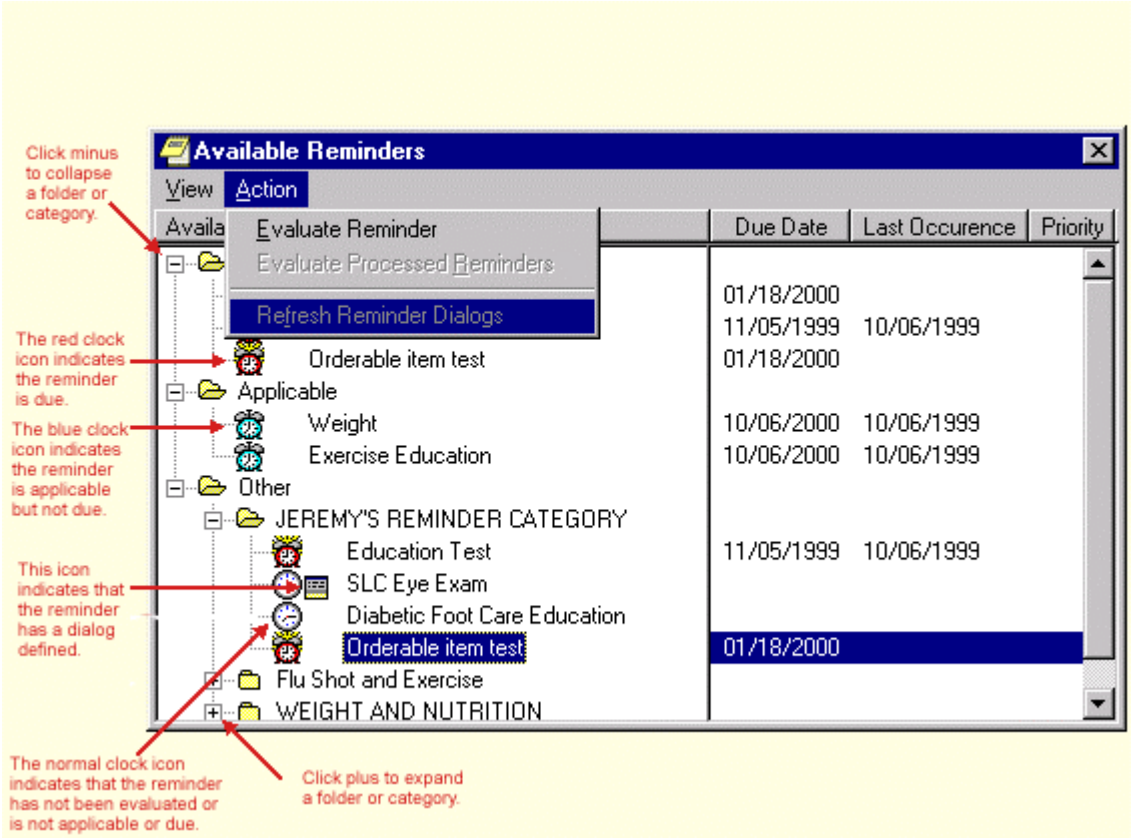
Applicable: The patient meets all the conditions for the reminder, but the appropriate time has not elapsed. For example, a flu shot is given once a year, but it has not been a year yet.

Other: Reminders have been defined, but were not specifically evaluated for the selected patient. An important education topic might be placed in Other.

Question Mark: A question mark on the Reminders button indicates that the reminders have not yet been evaluated. This appears when the patient's chart is first opened to a tab other than the Cover Sheet. Click the Reminders button or the Reminders drawer on the Notes tab to evaluate the reminders.

Grayed-out Alarm Clock: This icon means that there are no due nor applicable reminders, nor are there any reminder categories available.

If you click the button, you will be shown a branched or "tree" view of the patient's reminders such as the one shown below. The icons are also used in the tree view to identify the type of reminders.



Additional information on Reminders is located in the Cover Sheet section of this manual.

Patient Postings (CWAD)

Postings are a special type of Progress Notes. They contain critical information about a patient that hospital staff need to be aware of. The Postings button is visible on all tabs of the patient chart. It is located in the upper right corner of the dialog. The button is labeled Postings, and if a patient has postings, letters also appear on the button showing which categories of postings the a patient has:

- **Crisis Notes** (C) – Cautionary information about critical behavior or health of a patient. *Example: Suicidal attempts or threats.*
- **Warnings** (W) – Information about a patient of which medical center personnel need to be aware. *Example: Patient can be violent.*
- **Adverse Reactions/Allergies** (A) – Posting that tells staff about medications, foods, and other conditions to which the patient is allergic or may have an adverse reaction. *Example: Patient allergic to penicillin and latex.*
- **Directives** (D) – Also called Advanced Directives, Directives are recorded agreements that a patient and/or family have made with the clinical staff. *Example: DNR (Do Not Resuscitate) directive on file.*

For example, if the selected patient has a Crisis Note, a "C" shows on the button. If the patient has a Directive, a "D" appears on the button.

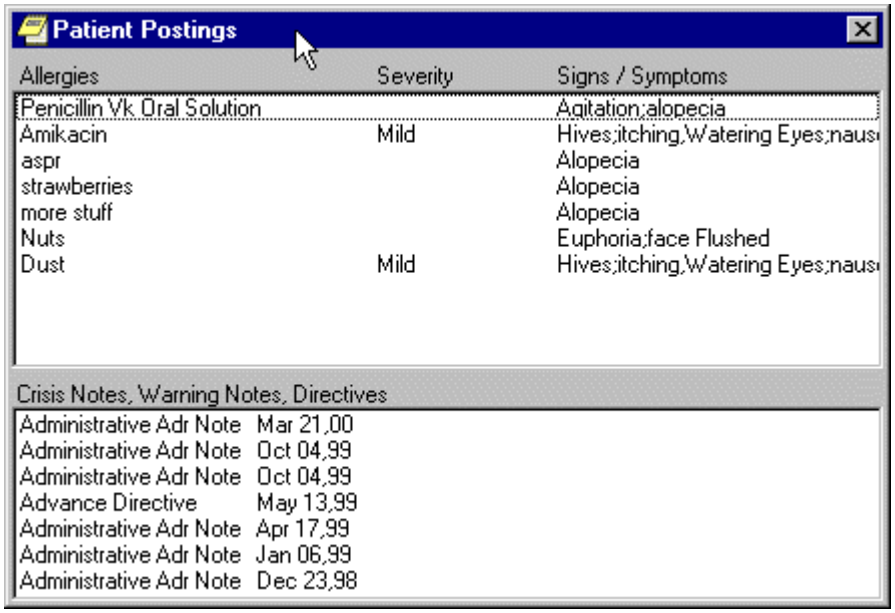
You can access the full text of a posting through the Postings button from any tab, or from the Cover Sheet, you can select a posting from the Adverse Reaction/Allergies area or the Postings area.

To create a new posting, you simply write a new progress note, and in the Progress Note Title drop-down list, select one of the following:

- Adverse Reaction/Allergy
- Clinical Warning
- Crisis Note
- Directive
- Warning

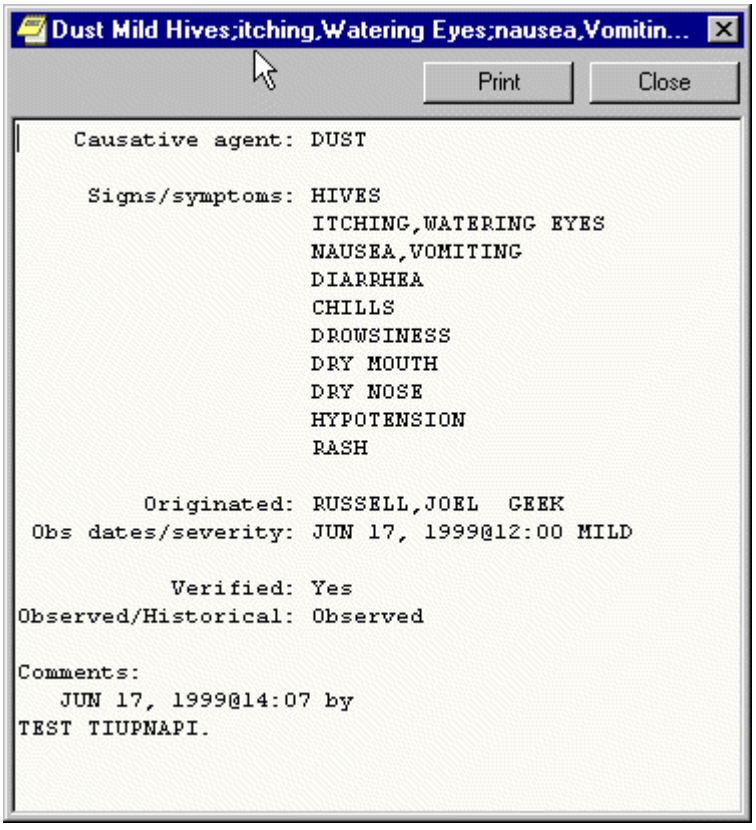
Viewing Postings

You can view postings from any tab using the Postings button.



To see the full text of the note through the Postings button, use the following steps:

1. Click the **Postings** button. A dialog containing all posting for the selected patient appears. The postings are divided into Adverse Reactions/Allergies and the other categories.
2. Click a posting to see a detailed explanation. A new window will appear with the full text of the posting in it as shown below.



3. When you finish with the posting, close the window with the full text by clicking the close button in the upper right corner of the window.

Electronic Signature

With CPRS you can electronically "sign" orders and documents. You can ask your clinical coordinator to set you up with an electronic signature code.

You must keep your signature code secret and use it properly to help keep an accurate medical record.

Generally, orders and documents such as notes and discharge summaries require an electronic signature. Orders are often signed as a group. Documents can be signed either individually or as a group if they have not been signed. You may have to use the **View | Unsigned Notes** (or Unsigned Discharge Summaries) to see if there are any notes you have not signed for a patient.

You will automatically be prompted for a signature when you do any of the following:

Select **File | Review / Sign Changes...** to see the orders you have entered for this patient in this session.

- Select **File | Select New Patient...**to close this record and open a new record.
- Select **File | Exit** or click the close button.

An option to sign is also available on the Orders, Notes, Consults, and D/C Summary tabs. It is usually under the Action menu or you can right-click in the main text area of a document or on a highlighted order.

Identify Additional Signers

With this feature, you can select others you want to sign this note. An alert will then be sent to that person that this note is ready for them to sign.

Identify Additional Signers helps you ensure that team members see a note. For example, one psychiatrist might identify another psychiatrist to sign the note to ensure that he or she agrees with an assessment.

To identify additional signers, use these steps:

1. After you have signed the note, select **Action | Identify Additional Signers**.

   -or-

   Right-click in the main text area and select **Identify Additional Signers**.
2. To identify a signer, locate the person's name (scroll or type in the first few letters of the last name) and click it.
3. Repeat step 2 as needed.
4. (Optional) To remove a name click the name under **Current Additional Signers** and click **Remove**.

When finished, click **OK**.

Add to Signature List

With Add to Signature List, you can place notes or discharge summaries for the same patient on a list where you can sign them all simultaneously.

This menu item might be used with **View | Unsigned Notes** or **View Uncosigned Notes** to place a number of notes you will sign at the same time. To sign them, you would use **File | Review / Sign Changes**.

To add an item to your signature list, click on **Add to Signature List** after completing or reviewing a note.

Sign Selected Orders

With CPRS, you can enter several orders and then sign them all simultaneously.

Orders are not released to services or activated until they are signed. There are two exceptions to this rule:

- Orders that can be designated as "signed on chart"
- Generic orders that don't require a signature

Remember that you also can use **File | Review / Sign Changes...**to see a summary of what you have entered for this patient in this session and sign those orders and documents that have not yet been signed.

To sign a number of orders, use these steps:

1. On the Orders tab, highlight the orders you want to sign. Use SHIFT and CTRL click in combination to select the desired orders.

   To select individual orders, use CTRL click.

   To select a range of items, click the order at the beginning of the range; then hold down the SHIFT key and click the order at the end of the range to select those two orders and all the orders between them.

2. Select **Action | Sign Selected**.

   -or-

   Right-click and select **Sign**.

3. Enter your signature code.
4. Click **OK**.

Review / Sign Changes

After you write orders or documents, such as progress notes, reports, or health summaries, you must "sign" them. Orders are not activated until they are signed. There are two exceptions to this rule:

- Orders that can be designated as "signed on chart"
- Generic orders that don't require a signature

The Review / Sign Changes screen shows you the orders and documents that you have entered for this patient during the current session. Each item that requires a signature has a check box in front of it.

All of the items that are checked will be signed when you enter your code. To deselect items, click the check box. Then, you enter your signature code to sign the orders and documents that are checked.

To electronically sign orders or documents, follow these steps:

1. To sign orders or documents and stay in this patient record, select **File | Review / Sign Changes....**

   To sign and move on to another patient, choose **File | Select New Patient**

   To sign and exit CPRS entirely, choose **File | Exit.**

2. Deselect any items that you do not want to sign by clicking the check box in front of them.

3. Enter your electronic signature code.

Note: If you don't have an electronic signature code, check with your clinical application coordinator.

4. Click OK.

What signing options you have, such as Save with Signature or No Signature Required, depends on the key you have been given. The signing options you can use for orders will be displayed at the bottom of the Review / Sign Changes dialog. Your clinical coordinator assigns your keys.

Sign Documents Now

After completing a note or discharge summary, you can immediately sign that document. The Sign Note Now and Sign Discharge Summary Now menu items will let you sign the current note.

These options sign only the current document you have created or edited.

Note: Notes and Discharge Summaries cannot be altered once they are signed. You can include additional signers of the document.

To sign the current note or discharge summary, use these steps:

1. Select **Action | Sign Note Now** (or **Sign Discharge Summary Now**).

   -or-

   Right-click in the document area and select **Sign Note Now** (or **Sign Discharge Summary Now**).

2. In the dialog that appears, type in your electronic signature code.

Note: If you don't have an electronic signature code, check with your clinical application coordinator.

3. Click **OK**.

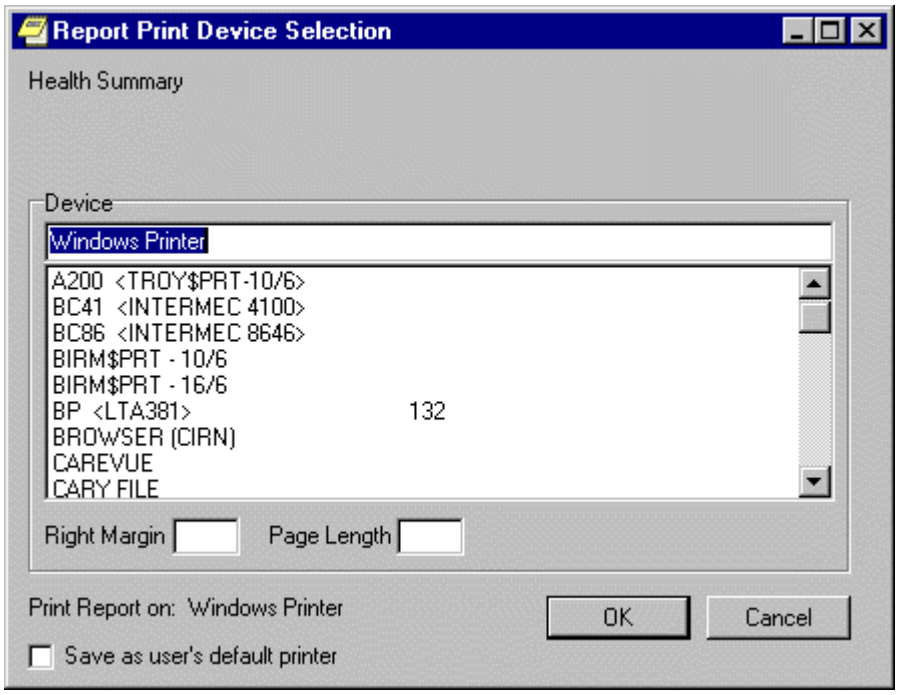
Printing from Within CPRS

You can print most reports, notes, and detailed displays from within the CPRS GUI.

To print graphics and charts, you will need to print to a Windows printer. Otherwise, for text documents, you can print to either a Windows or a VistA printer. The printer language used by Windows printers can accommodate graphics, while the language used by VistA printers cannot.

You can also now print graphics on a Windows printer from the Labs tab and the Vitals screen. You can use **File | Print Setup...** to set up a preferred printer for the current session and save it as the default for the user.

The dialog box shown below comes up when you select **File | Print** from the Notes tab. A similar dialog, without the Chart copy / Work copy option appears for items on other tabs. Many report boxes now have Print button on them to make it easier for you to print the information you need.

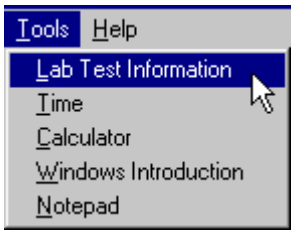


Normally, you do not need to enter a right margin or page length value. These values are measured in characters and normally are already defined by the device.

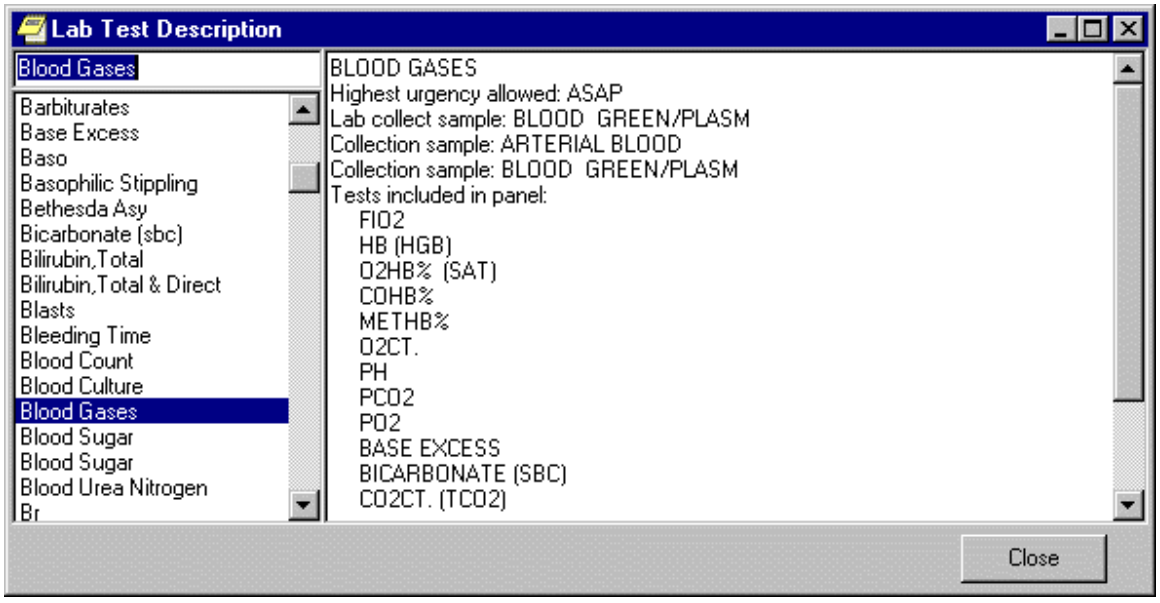
You will also still have the options to print your regular tasked jobs.

Tools from Within CPRS

The Tools menu contains one standard item called "Lab Test Information." Your site manages the remaining items on the Tools menu.



Selecting **Tools |Lab Test Information** menu option brings up the following dialog. Scroll through the list of lab test in the left field. When you select one, the results for that test will be displayed in the right field.

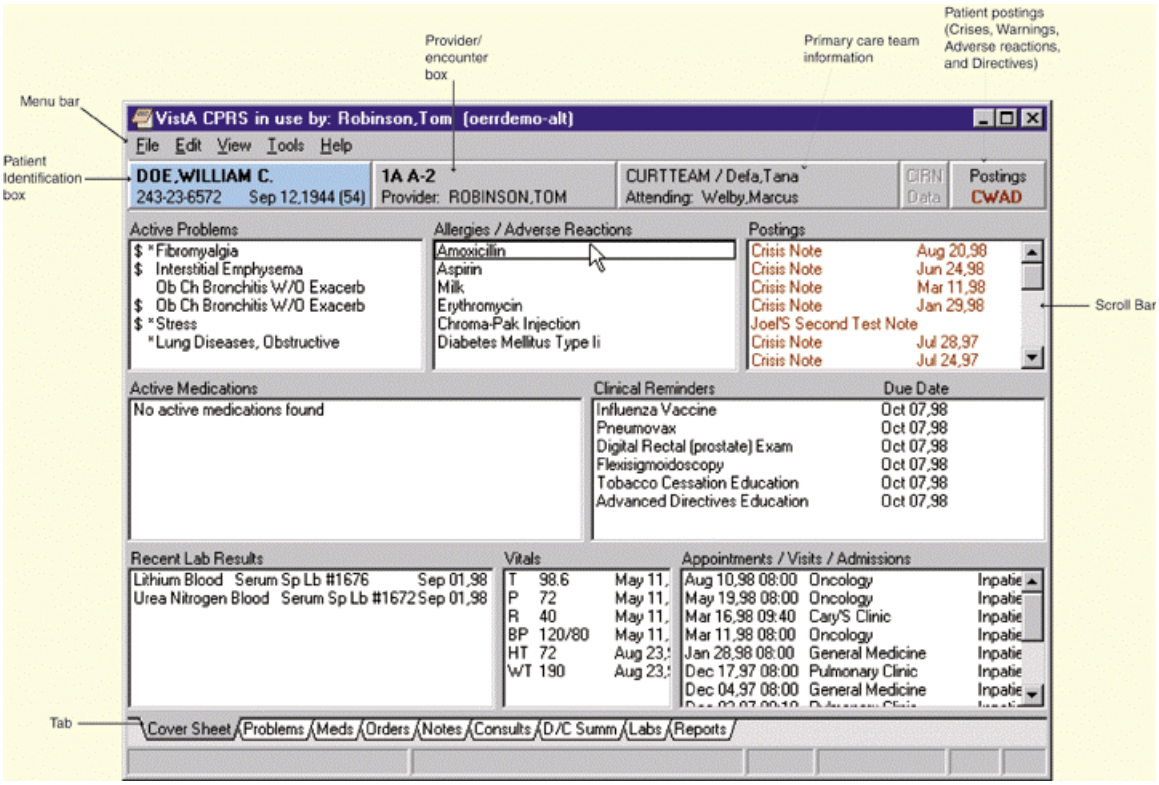


The Tools menu is a place where you can place items that you want to have quick access to when within CPRS. For example, you might want to have an item for a word processor or a local program you use.

The tools menu is a menu that you can customize. It can contain menu items to take you to other parts of VISTA, to local policies, to word-processing programs, to the Web, or to whatever your site chooses to put on this menu. An option for adding items to the Tools menu is on the CPRS Configuration Menu (Clin Coord). Talk to your Clinical Coordinator if you wish to have something added.

Cover Sheet

The Cover Sheet will be the first screen you see after opening a patient record unless your site defines another tab as the initial tab. It presents a quick overview of a patient's condition and history. It shows active problems, allergies and postings, active medications, clinical reminders, lab results, vitals, and a list of appointments or visits.

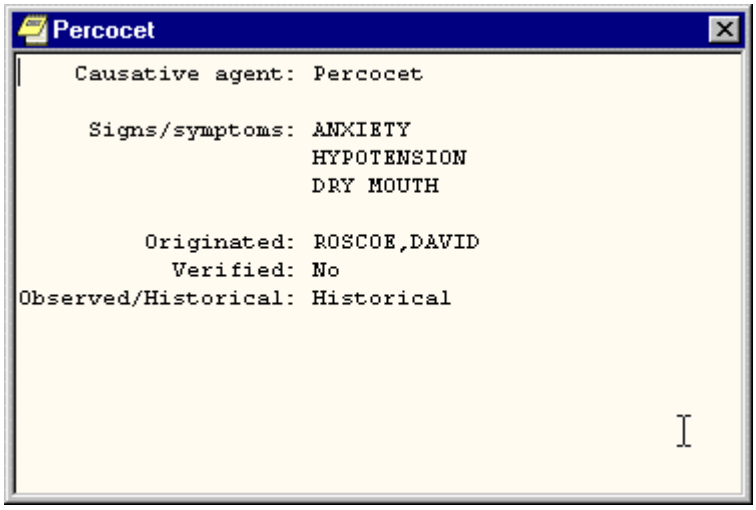


You can quickly review the active problems (asterisks identify acute problems, and dollar signs identify unverified problems). Scroll bars beside a box mean that more information is available if you scroll up or down. Single-click on one of the five menus: File, Edit, View, Tools, or Help, to see choices of things you can do or other options available to you.

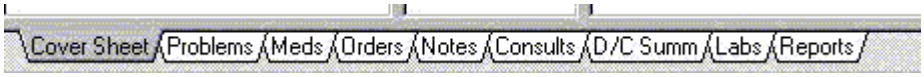
The File menu contains three commands that you will use often:

- **Select New Patient** brings up the Patient Selection dialog.
- **Update/Provider/Location** brings up a dialog that enables you to change the clinician or location of an encounter.
- **Review/Sign Changes** enables you to view the orders you have placed that require an electronic signature, select the orders you want to sign at this time, and enter your electronic signature (if you are authorized to sign them).

Click on any item to get more detailed information. For example, you can click the Patient Identification box (or button) to get more information about the patient. You can click on a Visit to see details. For example, a patient could have Percocet listed in the Allergies/Adverse Reactions dialog. By clicking on it, you would see the following detail window.



Click on a tab at the bottom of the screen to go to that section of the patient chart.



Navigating a Patient Chart

The CPRS Windows interface mimics the paper chart of a patient's record, but CPRS makes locating information easier. With the Patient Selection screen, you can quickly bring up a record for any patient on the system. The Cover Sheet summarizes important information about the patient. Along the bottom of this dialog or page are a number of tabs that will quickly take you to the part of the chart you need to see. For example, you might want to see Progress Notes, Problems, Summaries, Medications, Lab Tests, or place new orders:

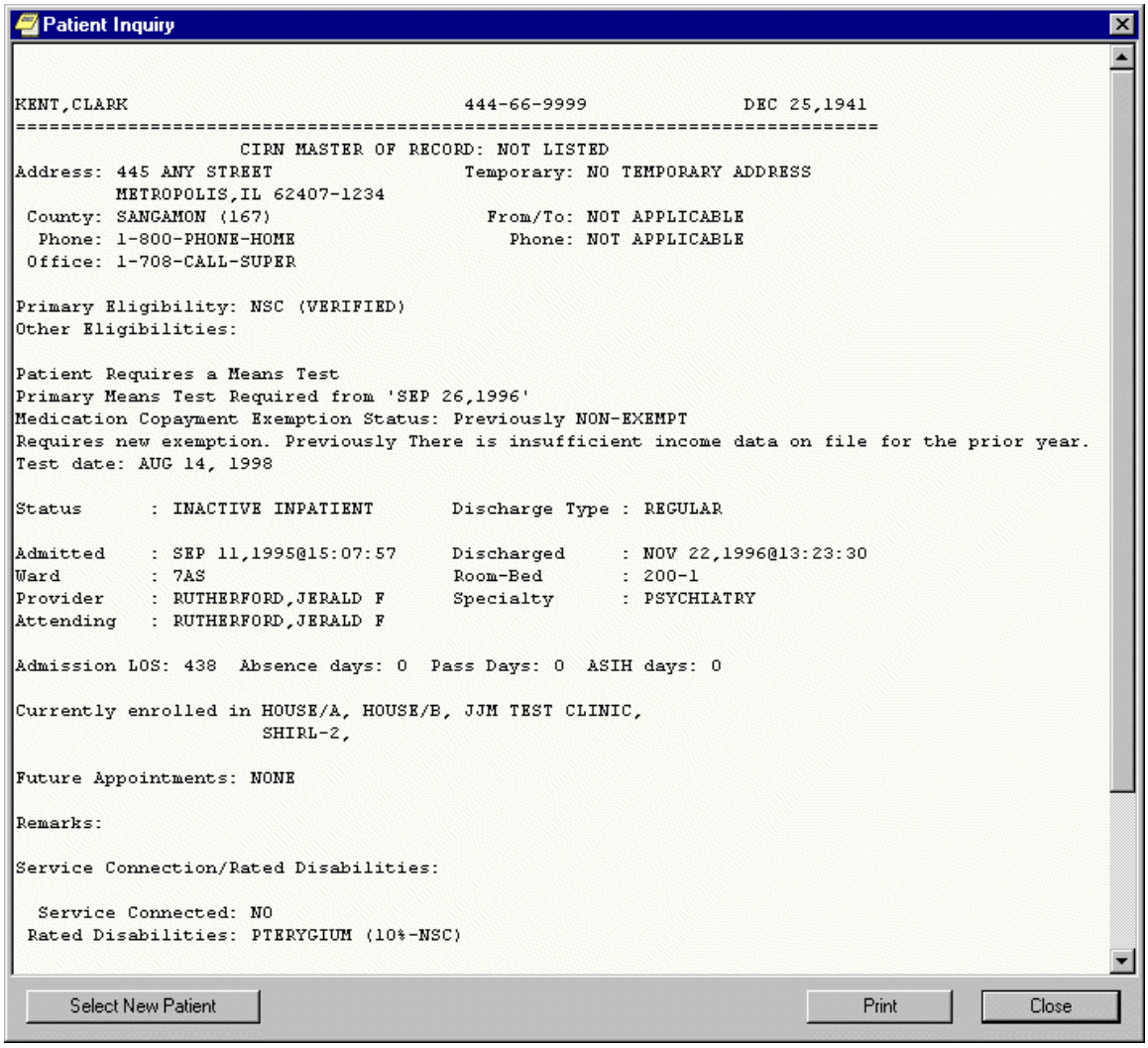
To go to a different part of the patient chart, click on the appropriate tab at the bottom of the chart or choose **View | Chart Tab**, and then select the desired tab.

Additional Patient Information

You can obtain additional patient information by clicking the Patient ID box located on the upper left of the dialog. You can access this button from any chart tab.

The button shows the patient's name (in bold), Social Security number, date of birth, and age (as shown in the graphic below). If you click the button, CPRS brings up a window containing additional information such as the patient's address, the attending physician, date of admittance, and so on.

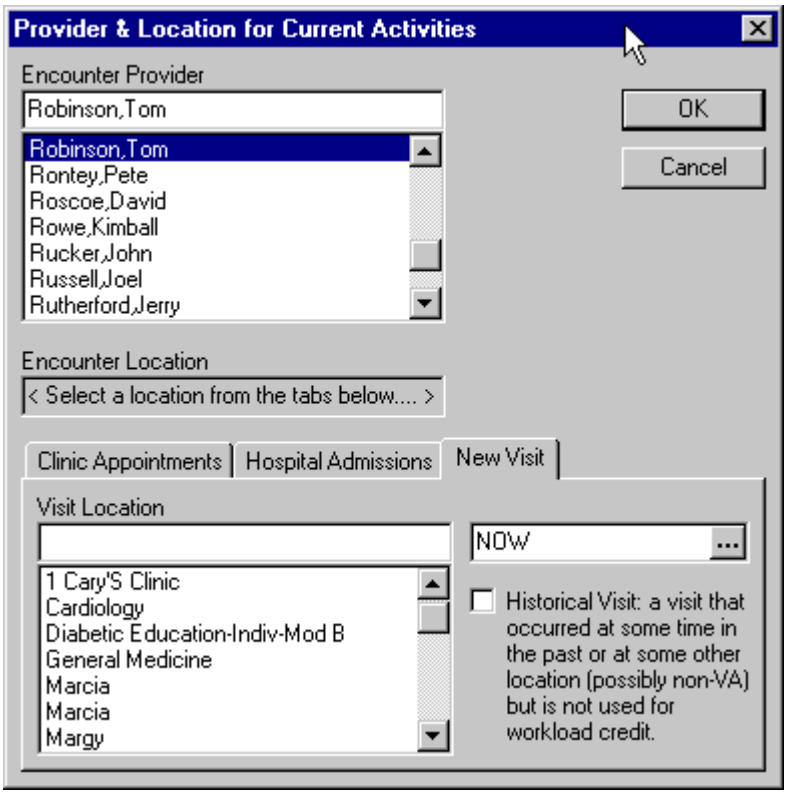
To obtain further information about a patient, click the Patient ID box.



To close the Patient Inquiry window and return to the Cover Sheet, click Close or click **File | Select New Patient** from the menu on the Cover Sheet to select another patient.

Changing Encounter Information

Encounter information is required before you can enter orders, write notes, or other kinds of activities.



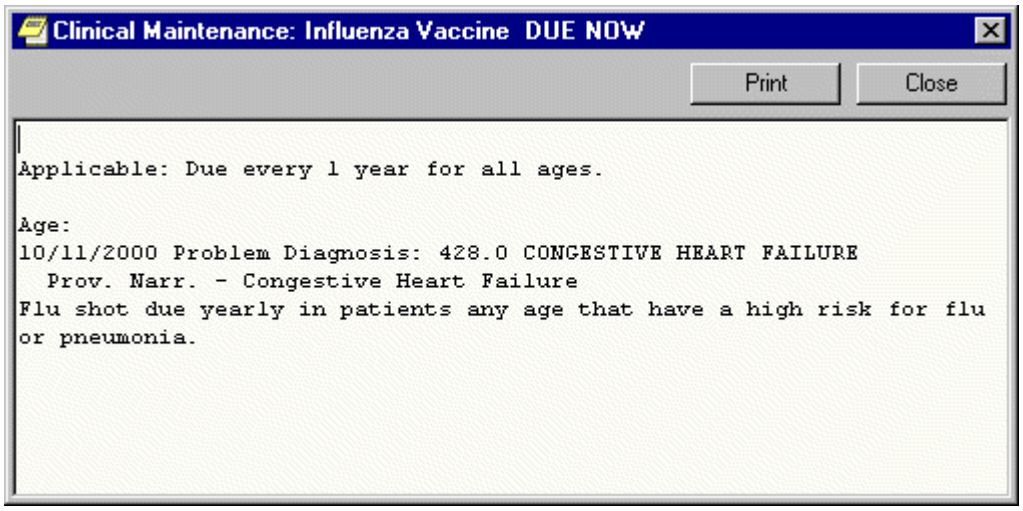
It does not count for workload credit. For that, you must enter encounter form data.

To enter or change the Encounter provider, follow the steps below:

1. If you are already in the Provider / Encounter dialog skip to step 2. Otherwise, from any chart tab, click the Provider / Encounter box located in the top center portion of the dialog.
2. Locate and click the provider for this encounter in the list box.
3. Click the tab of the correct encounter category for this visit:
   - Clinic Appointments
   - Hospital Admissions
   - New Visit
4. Select a location for the visit from the choices in the list box.
5. If you selected a Clinic Appointment or Hospital Admission, skip to step 7. If you are creating a New Visit, enter the date and time of the visit (the default is NOW).
6. Click a visit category from the available options (such as, Historical) and click OK.
7. When you have the correct provider and location, click OK.

Viewing Clinical Reminders

From the Cover Sheet, you can double-click on any of the Clinical Reminders listed and obtain a description of the reminder and why it applies to the currently selected patients.



To Process Reminders, you must go to the Notes tab.

Viewing Vitals

CPRS displays the patient's most recent Vitals in the Vitals area (in the lower center portion of the Cover Sheet).

To view the selected patient's vitals history, use these steps:

1. Click on a value in the Cover Sheet's Vitals area. The Vitals dialog appears.
2. In the dialog's upper left, click the time period you want to view (Today, All Results, Date Range, etc.).
3. Click the vital category you want to view (Temperature, Pulse, Respiration, Blood Pressure, Height, Weight, or Pain).
4. Adjust the graph features as desired:

Click Zoom and then enlarge a part of the graph by clicking and dragging from above and left of the area to below and to the right of it.

Click 3D to make the graph into a simple three-dimensional representation.

Click Values to show the numerical value of each graph point.

Reviewing Postings

Postings are a special type of Progress Notes. They contain critical information about a patient that hospital staff need to be aware of. The Postings button is visible on all tabs of the patient chart. It is located in the upper right corner of the dialog.

You can access the full text of a posting through the Postings button from any tab, or from the Cover Sheet, you can select a posting from the Adverse Reaction/Allergies area or the Postings area.

To create a new posting, you simply write a new progress note, and in the Progress Note Title drop-down list, select one of the following:

- Adverse Reaction/Allergy
- Clinical Warning (which is the same as Warning)
- Crisis Note
- Directive
- Warning

Notifications and Alerts

Notifications are messages that provide information or prompt you to act on a clinical event. Clinical events, such as a critical lab value or a change in orders trigger a notification to be sent to all recipients identified by the triggering package (Lab, CPRS, Radiology, and so on).

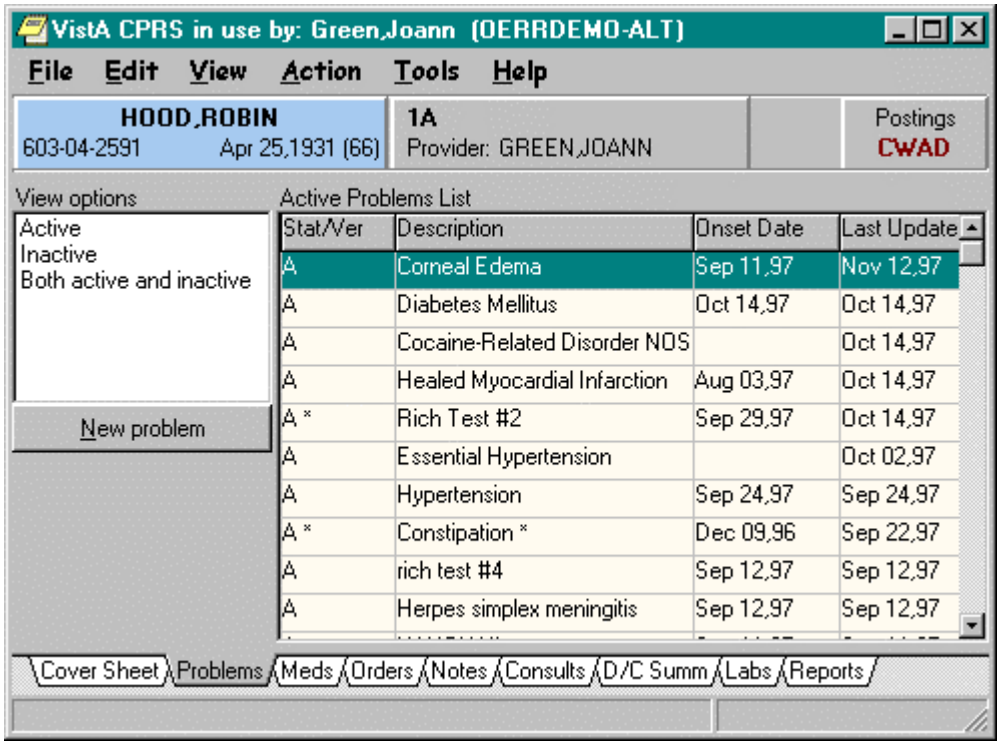
CPRS places an "I" before information notifications. Once you view (process) information notifications, CPRS deletes them. When you process notifications that require an action, such as signing an order, CPRS brings up the chart tab and the specific item (such as a note requiring a signature) that you need to see.

Note: When CPRS is installed, all notifications are disabled. IRM staff and clinical coordinators set site parameters through the Notifications Management Menus in the List Manager version of CPRS that enable specific notifications. Notifications are initially sent to all users. Users can then disable unwanted notifications through List Manager's Personal Preferences.

Clinical Notifications are displayed on the bottom of the Patient Selection screen when you log in to CPRS. Only notifications for your patients are shown.

Problem List

The Problem List documents a patient's problems. It provides clinicians with a current and historical view of the patient's health care problems across clinical specialties. It allows each identified problem to be traceable through the VISTA system in terms of treatment, test results, and outcome.



You have a choice of how to display a patient's problems: active problems only, inactive problems only, both active and inactive problems, and problems for a selected service or provider by customizing your view of the problem list.

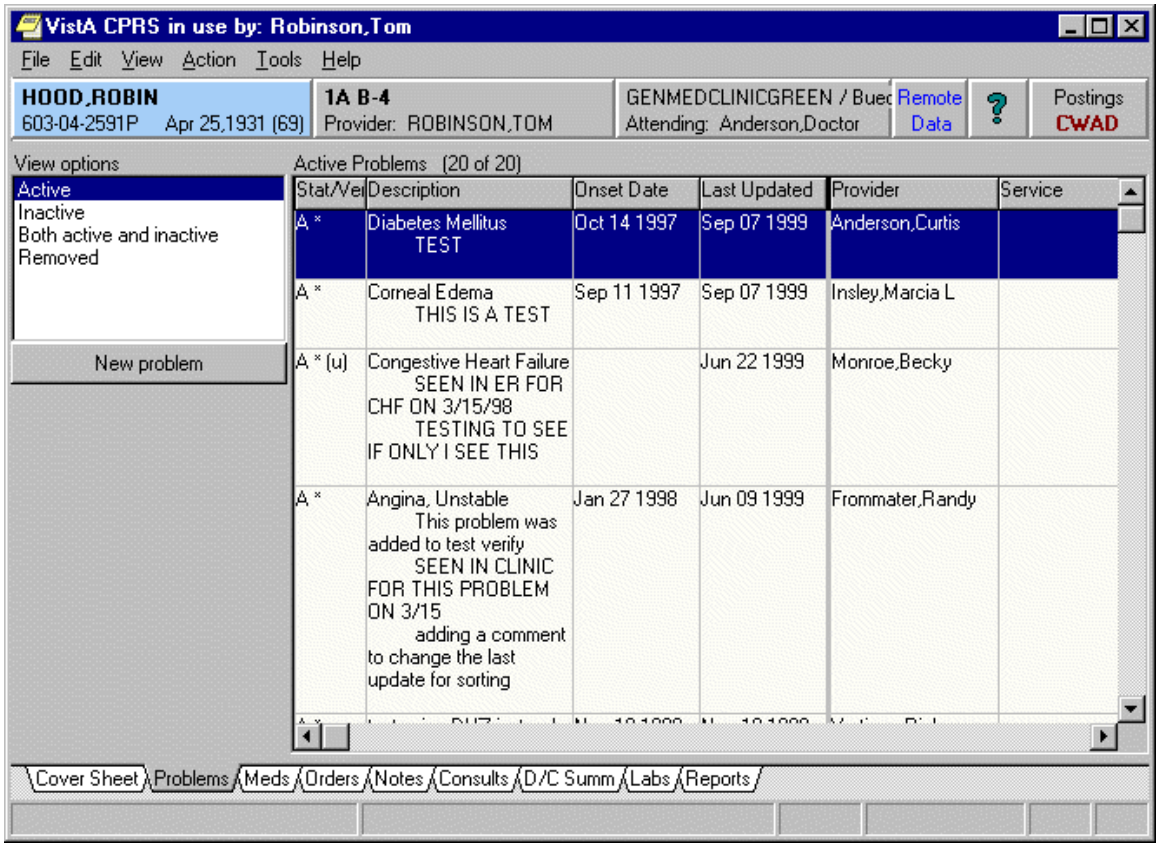
You can change the view, add, deactivate, remove, verify or annotate problems.

Changing Views on the Problem List

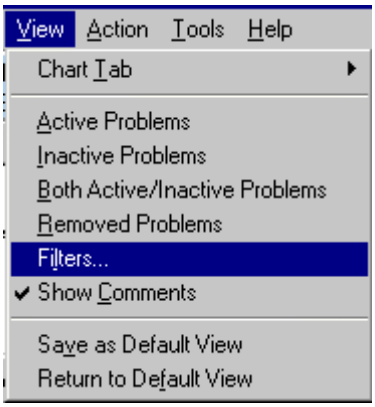
Changing the view of the Problem List allows you to focus the list of problems on one of several criteria. Focusing the list will speed up the selection process.

You may change the Problems List view to only include the following problems:

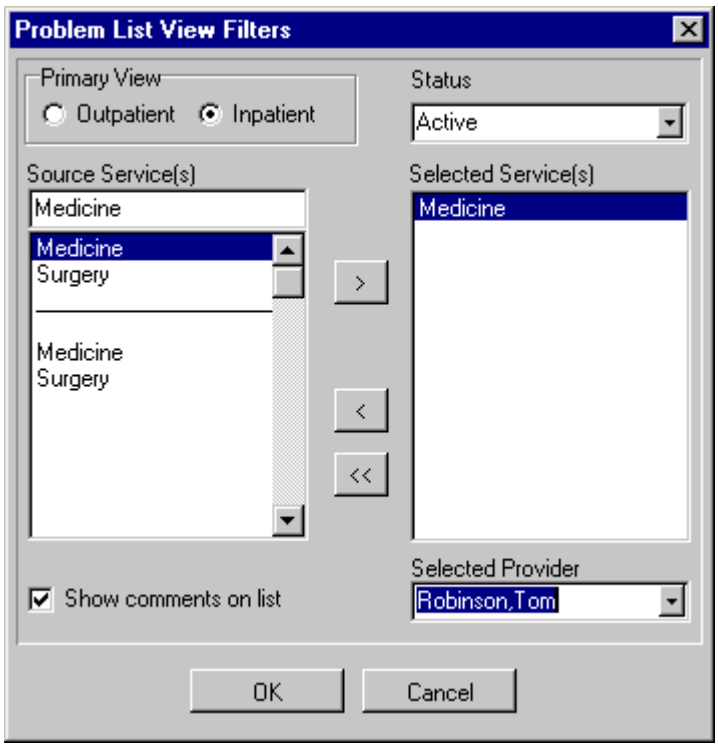
- Active
- Inactive
- Active and Inactive
- Removed



To change the view, click on any of the options listed in the View options field or click on View on the menu.

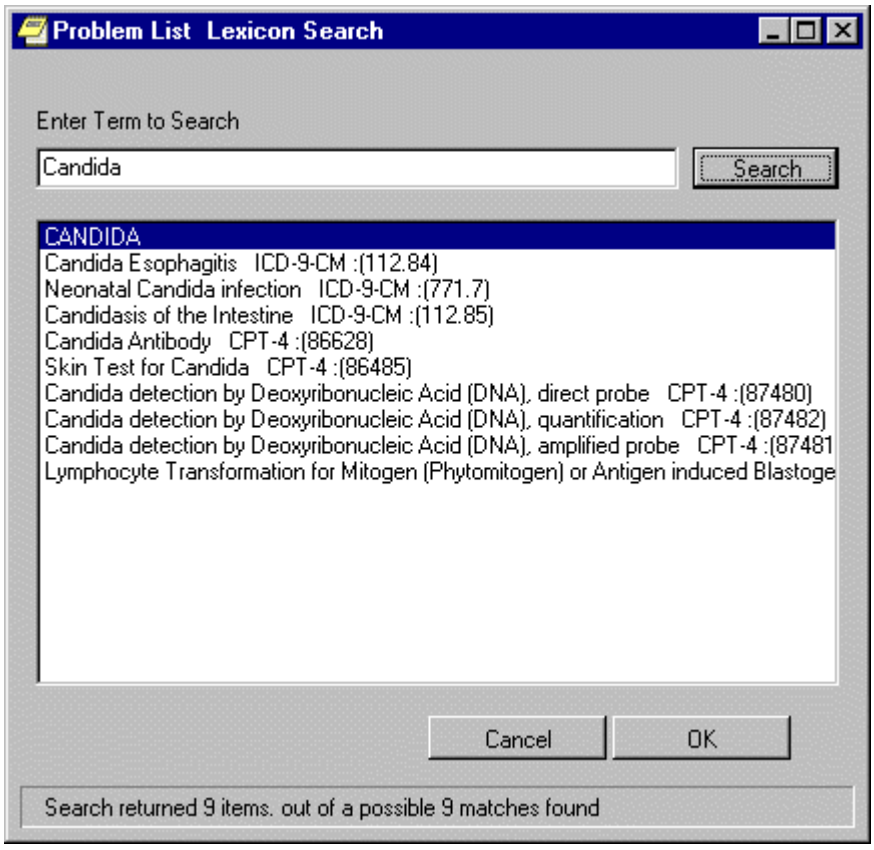


You may select the Filters… option on the menu to further focus the list of problems you wish to have displayed. From the Filters dialog, you may choose to display problems by any combination of Status, Source Clinic (which is listed when you select Outpatient), Source Service (which is listed when you select Inpatient), and Provider.



Adding a Problem

You add a new problem from the Problems tab. From this tab, you can add, remove, change, verify, and annotate a problem.



To add a new problem to a patient's problem list, use these steps:

1. Click the Problems tab.
2. Click New Problem.

Note: If you have not defined the provider or location, you will be prompted for this encounter information.

3. Select a problem from the list or search the lexicon for the problem by clicking **Other** on the lower left side of the Problems tab, entering terms that describe the problem in the Problem List Lexicon Search field, and then pressing **Enter** or click **Search**. When the list appears, locate and click on the problem.
4. Enter information about the problem, such as whether it is acute or chronic, treatment factors (Service Connected, Radiation, Agent Orange, or Environmental Contaminants), the Date of Onset, the provider, and the clinic.
5. Add a comment if you wish by clicking **Add Comment** and entering the comment in the dialog that appears. Then click **OK**.
6. Click **OK** again.

Annotating a Problem

To annotate a problem, use these steps:

1. Click on the problem in the problem list.
2. Select **Action | Annotate...** or right-click the problem and select **Annotate...** from the pop-up menu.
3. Enter your annotation in the dialog that appears (up to 60 characters).
4. Click OK.

Changing a Problem

CPRS allows you to change existing problems.

To change a problem on a patient's problem list, use these steps:

1. Click the Problems tab.
2. Click on the problem in the list box that you want to change.
3. Select **Action | Change**.
4. Enter the desired changes.
5. Add or remove a comment if desired.

Note: A comment can be as many as 60 characters (including spaces) in length.

6. Click **OK**.

Note: When you view the details of a problem, you will see who changed the problem and when.

Deactivating a Problem

To deactivate a problem on a patient's problem list, use the following steps:

1. Click on a problem in the list box.
2. Select **Action | Inactivate.**

Removing a Problem

A problem is not removed from the database because things "pointing" to it might be broken if it is removed. A field in the problem record can be "flagged" with an "H" and the problem will be HIDDEN. Any software that runs on the database must look at the field to see if it is hidden or not. The hidden record will not appear on any reports or lists and will appear to the user that it has been removed. Actually it is only removed from sight.

To remove a problem from a patient's problem list, use these steps:

1. Click on the problem.
2. Select **Action | Remove** or right-click the problem and click Remove.

Verifying a Problem

To verify a problem on a patient's problem list, use these steps:

1. Click on the problem in the problem list.
2. Select **Action | Verify** or right-click the problem and click **Verify** on the pop up menu.

Customizing the Problem List

On the Problems tab, you can sort the problem list by problem status or use the view filtering to get a more specific list of problems. You can sort the list to see the following:

- Active Problems
- Inactive Problems
- Both Active/Inactive Problems
- Removed Problems

To sort the problem list by status, do the following:

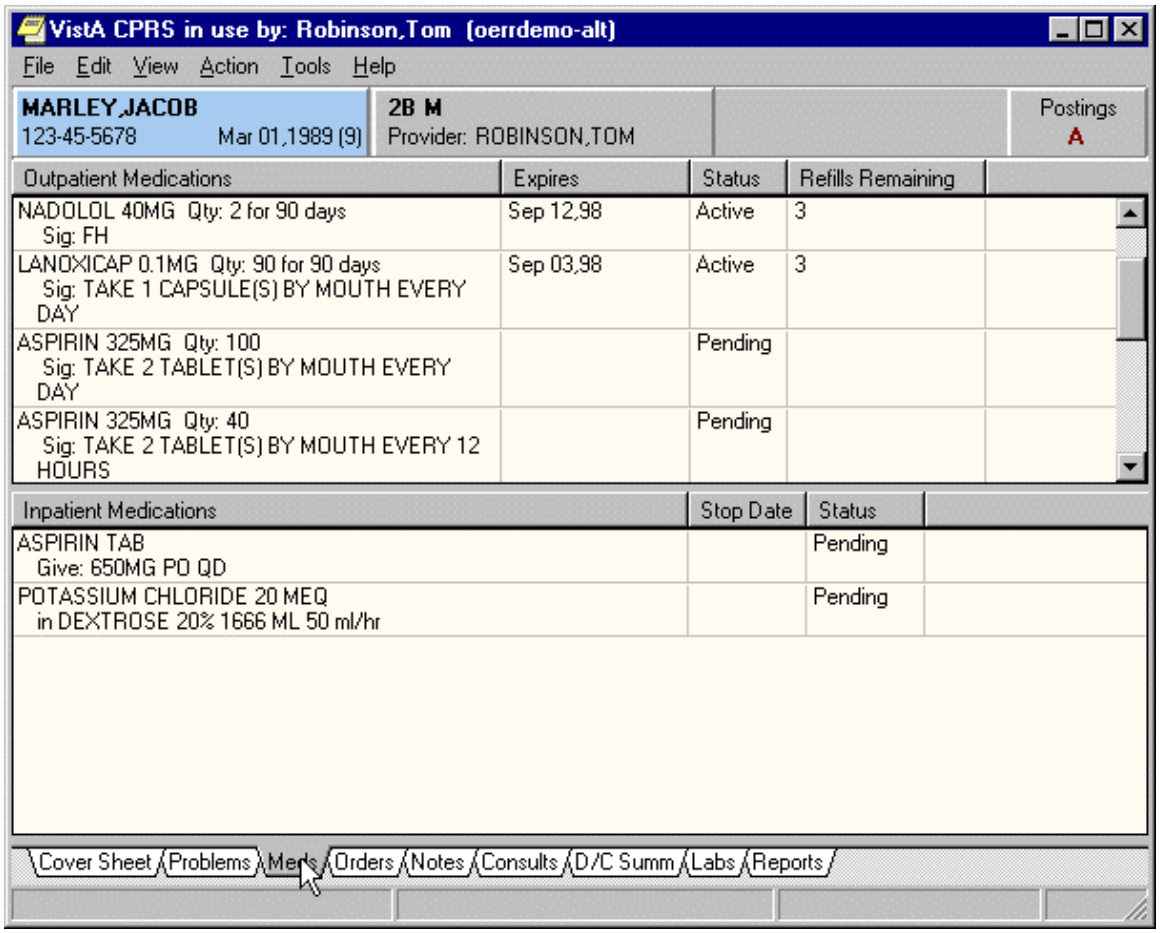
1. Click on the Stat/Ver column heading in the View Options list box on the left of the dialog or **Select View** and then the desired status. To further customize the problems displayed, use these steps
2. Select **View | Filters**.
3. Specify some or all of these filtering criteria:
    - Patient type (inpatient, outpatient, or both)
    - Provider
    - Locations or services
5. Click **OK**.

Meds

The Meds tab is a listing of medications for the selected patient. Inpatient and Outpatient Medications are listed in different areas. You can see in the graphic below the information that CPRS presents for each medication. Depending on your needs, the Outpatient Medications field can be enlarged or reduced in size by holding the cursor near the bottom edge of the field until it turns into a double-line with up and down arrow heads. Click and drag the field to the size you desire.

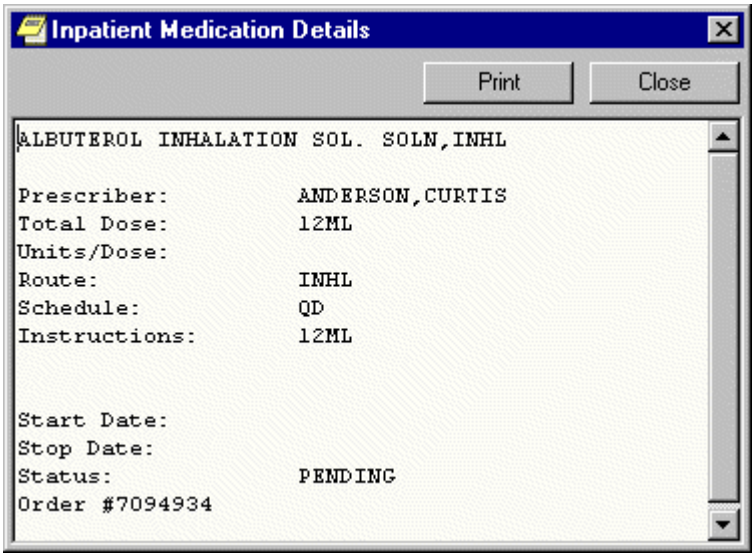
To get additional details on a specific medication order, double-click the entry or select **View | Details**. To take other actions, ordering a new medication, changing a medication order, or changing a medication order status (discontinue, hold, or renew), you use the Action menu or right-click on a medication.

You can also place orders for new medications from the Orders tab.



Changing Views on the Meds tab

Changing view on the Meds tab simply reformats the information for a particular medication so that it can be printed or viewed. You may double-click on any medication either the Outpatient of Inpatient lists or you may highlight any medication and click on **View | Details**.



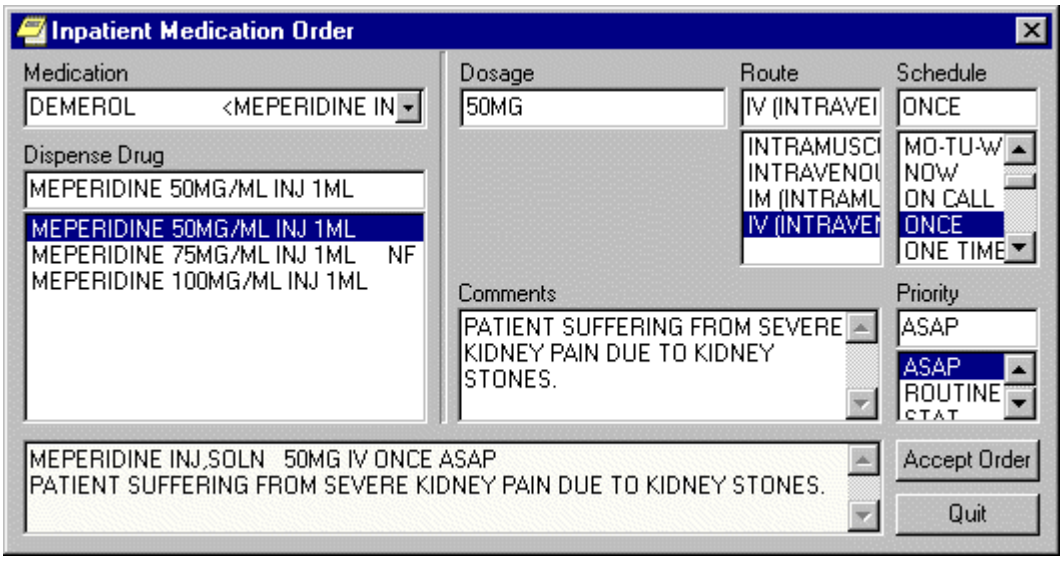
Ordering Inpatient Meds

To write a new Inpatient Medications order, use these steps:

1. From the Meds tab, select **Action | New Medication**.

   -or-

   From the Orders tab, click **Meds** and then **Inpatient** in the Write Orders box.



Note: If no encounter information has been entered, the Encounter Information dialog appears. A preliminary order check is done and a dialog may appear to provide you with pertinent information.

2. Locate and click on the desired medication in the Medication list box.

3. Locate and click the drug to be dispensed from the Dispense Drug list.

Note: For order checking to work correctly, you must enter the dispense drug.

4. Enter or select Dosage, Route, Schedule, and Priority from the boxes of the ordering dialog that appears.

Note: If you do not complete the mandatory items or if the information is incorrect, CPRS sends a message that tells you that the information is incorrect and shows you the correct type of response.

5. Add comments, if desired.
6. Click Accept **Order**.
7. Enter another medication order or click **Quit**.

Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

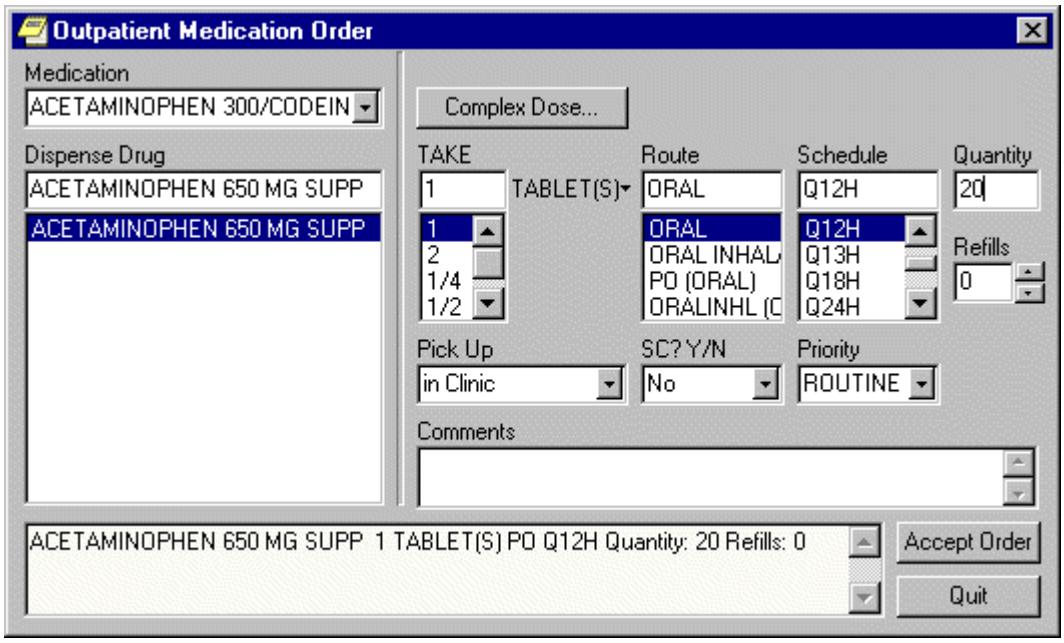
Ordering Outpatient Meds

Outpatient medications can be ordered in either simple doses or complex doses.

Simple Dose

To write a simple dose of a new Outpatient Medications order, use these steps:

1. Click the Orders tab.
2. Click Meds, Outpatient in the Write Orders list box.



Note: If no encounter information has been entered, the Encounter Information dialog appears. Also, a preliminary order check is done and a dialog may appear to provide you with pertinent information.

3. Locate and click the medication in the list box by typing the first few letters in the name and then scrolling to find it (or simply scroll to find the name) and then click it.
4. Locate and click the form of the drug that should be dispensed from the Dispense Drug list.
6. Enter the number of tablets, the amount of liquid suspension, etc. that the patient should take.
7. Select values for the Route and Schedule fields.

8. Select the other fields Quantity, Pick Up, Service Connection, Priority, and Refills by clicking on the appropriate response in the list boxes or typing in a number.
9. You can also add a comment if desired.
10. Click **Accept Order**.

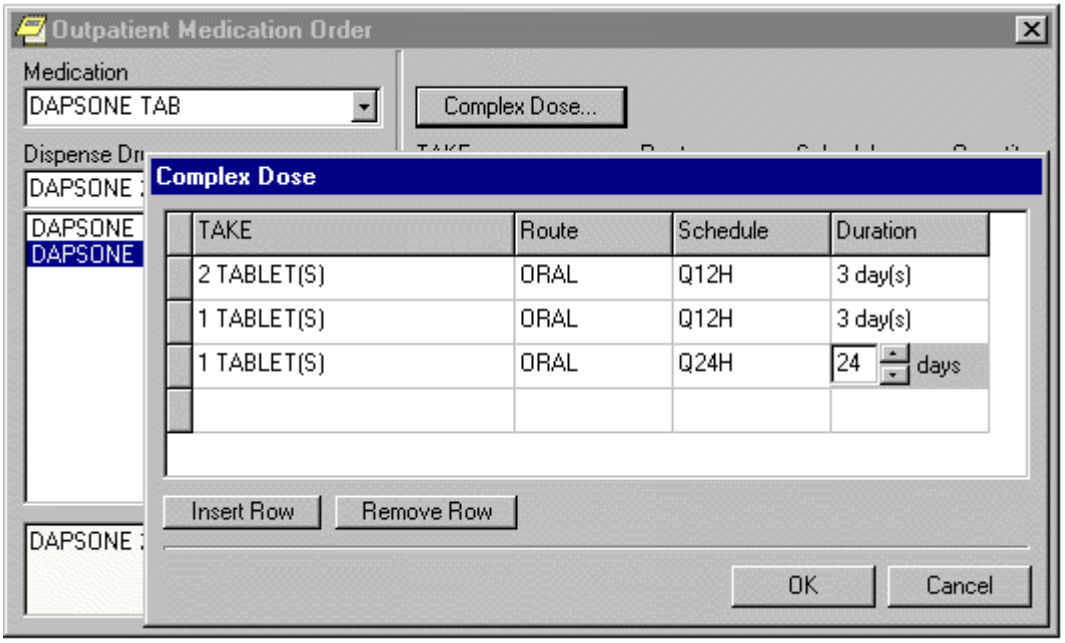
If you are finished ordering outpatient medications, click **Quit**.

Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Complex Dose

To write a new Outpatient Medications order, use these steps:

1. Click the Orders tab.
2. Click Meds, Outpatient in the Write Orders list box.



Note: If no encounter information has been entered, the Encounter Information dialog appears. Also, a preliminary order check is done and a dialog may appear to provide you with pertinent information.

3. Locate and click the medication in the list box by typing the first few letters in the name and then scrolling to find it (or simply scroll to find the name) and then click it.
4. Locate and click the form of the drug that should be dispensed from the Dispense Drug list.
5. Click on **Complex Dose…** On the Complex Dose dialog, click on each cell of the TAKE, Route, Schedule and Duration columns and make the appropriate selection.
6. Repeat Step 5 on a new row on the dialog for each element in the Complex Dose.
7. Select the other fields Quantity, Pick Up, Service Connection, Priority, and Refills by clicking on the appropriate response in the list boxes or typing in a number.

8. You can also add a comment if desired.

9. Click **Accept Order**.

If you are finished ordering outpatient medications, click Quit.

Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Hold Orders

Only active orders may be placed on hold. Orders placed on hold will continue to show under the ACTIVE heading on the profiles until it is removed from hold. An entry is placed in the order's Activity Log recording the person who placed/removed the order from hold and when the action was taken.

To place a medication on hold, use these steps:

1. Click the Meds tab.

2. Locate and click the medication.

3. Select **Action | Hold**.

Renewing Orders

Active orders may be renewed. In addition, inpatient medication orders that have expired in the last four days and outpatients medication orders that have expired in the last 120 days may be renewed. The default Start Date/Time for a renewal order is determined as follows:

Default Start Date Calculation = NOW

The default start date/time for the renewal order will be the order's Login Date/time.

Default Start Date Calculation = USE NEXT ADMIN TIME

The original order's Start Date/Time, the new order's Login Date/Time, Schedule, and Administration Times are used to find the next date/time the order is to be administered after the new order's Login Date/Time. If the schedule contains "PRN" any administration times for the order are ignored.

Default Start Date Calculation = USE CLOSEST ADMIN TIME

The original order's Start Date/Time, the new order's Login Date/Time, Schedule, and Administration Times are used to find the closest date/time the order is to be administered after the new order's Login Date/Time. If the schedule contains "PRN" any administration times for the order are ignored.

After the new (renewal) order is accepted, the Start Date/Time for the new order becomes the Stop Date/Time for the original (renewed) order. The original order's status is changed to RENEWED. The renewal and renewed orders are linked and may be viewed using the History Log function. Once an order has been renewed it may not be renewed again or edited.

Discontinuing Orders

When an order is discontinued, the order's Stop Date/Time is changed to the date/time the action is taken. An entry is placed in the order's Activity Log recording who discontinued the order and when the action was taken. Pending and Non-verified orders are deleted when discontinued and will no longer appear on the patient's profile.

To discontinue an order, use these steps:

1. Click the Orders tab.
2. Click the order you want to discontinue.
3. Select **Action | Discontinue/Cancel.** A dialog may appear asking for the clinician's name and the location (encounter information).
4. Click the name of the clinician (you may need to scroll through the list), click the encounter location, and then click **OK**. Another dialog will appear asking for the reason why the order is being discontinued.
5. Select the appropriate reason from the box in the lower left of the dialog and click **OK**.

Changing Orders

To change a Medication order:

1. Click either the Meds tab or the Orders tab.
2. Click the medication order to select it.
3. Select **Action | Change...** or right-click the order and click **Change....**

Note: If the provider or location has not been defined, you will be prompted for that information.

4. Complete the changes as appropriate in the dialog box that appears on the screen.
5. Click **Accept**.
6. You may sign the order now or later.

Placing a Medication Order

To write a new Inpatient Medications order, use these steps:

1. From the Meds tab, select **Action | New Medication**.

   From the Orders tab, click Meds, then select Inpatient in the Write Orders box.

Note: If no encounter information has been entered, the Encounter Information dialog appears. A preliminary order check is done and a dialog may appear to provide you with pertinent information.

2. Locate and click on the desired medication in the Medication list box.
3. Locate and click the drug to be dispensed from the Dispense Drug list.

Note: For order checking to work correctly, you must enter the dispense drug.

4. Enter or select Dosage, Route, Schedule, and Priority from the boxes of the ordering dialog that appears.

Note: If you do not complete the mandatory items or if the information is incorrect, CPRS sends a message that tells you that the information is incorrect and shows you the correct type of response.

5. Add comments, if desired.

6. Click **Accept Order**.

7. Enter another medication order or click **Quit**.

Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Viewing a Meds Order

When you select the Meds tab, you see a list of medications that have been ordered for this patient.

To view a patient's medications by category, use these steps:

1. Click the Meds tab.

2. Select View then one of the following menu items:

   - Current Active
   - Expiring
   - VA Drug Class
   - Drug Name

You can get a more detailed display of each order by double-clicking the order.

Note: You can also review or add medication orders from the Orders tab.

When ordering medications, you can order Outpatient Pharmacy or Inpatient Meds, which includes IV Fluids and Unit Dose.

Transfer Outpatient Meds Order to Inpatient

You can transfer outpatient medications to inpatient medications with CPRS. CPRS will tell you if the medication cannot be changed to an inpatient medication.

Because of the differences, you will go through each order and make the necessary changes.

To transfer the medication to inpatient, use these steps:

1. Click the Meds tab.

2. Select the outpatient medications you want to transfer. Hold down the CTRL key to select more than one medication. Hold down the SHIFT key and click on the first and last medications to select a range.

3. Select **Action | Transfer to Inpatient**.

4. Enter the necessary information for the first order and click Accept.

5. Repeat step 4 as needed for the selected medications.

6. When finished, you can sign the orders now or wait until later.

Transfer Inpatient Meds Order to Outpatient

You can transfer inpatient medications to outpatient medications with CPRS. CPRS will tell you if the medication cannot be changed to an outpatient medication.

Because of the differences, you will go through each order and make the necessary changes.

To transfer the medication to outpatient, use these steps:

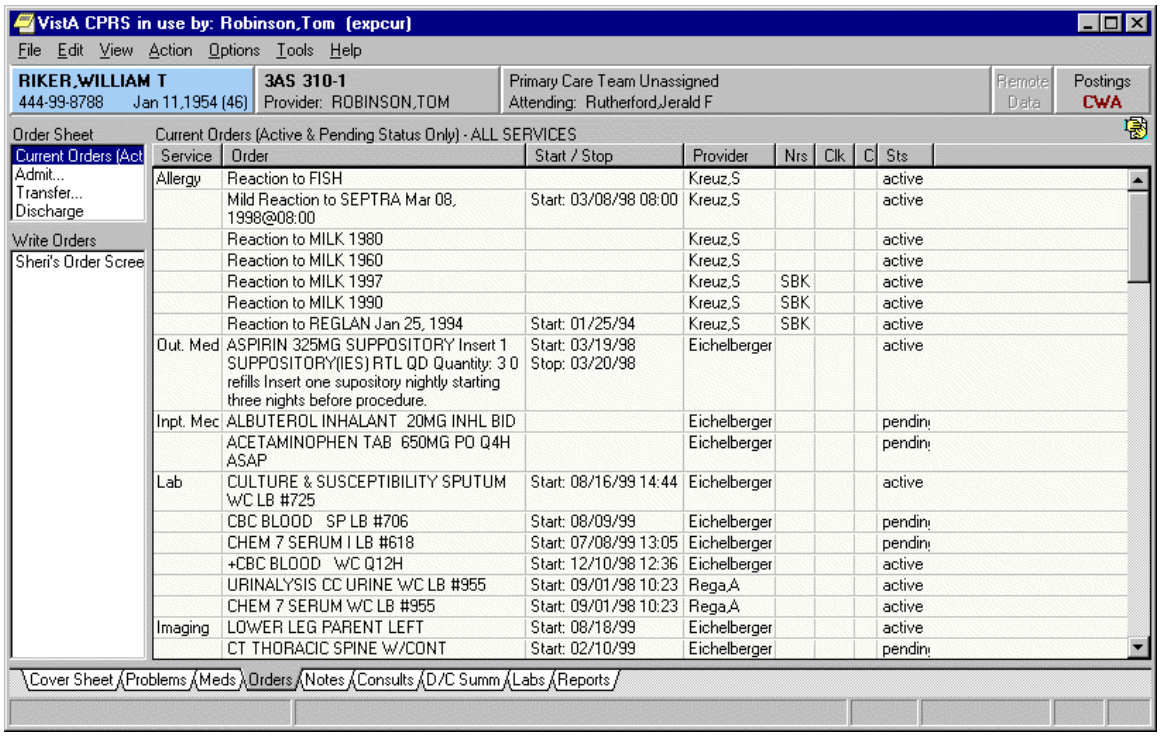
1. Click the Meds tab.
2. Select the inpatient medications you want to transfer. Hold down the CTRL key to select more than one medication. Hold down the SHIFT key and click on the first and last medications to select a range.
3. Select **Action | Transfer to Outpatient**.
4. Enter the necessary information for the first order and click **Accept**.
5. Repeat Step 4 as needed for the selected medications.
6. When finished, you can sign the orders now or wait until later.

Orders

On the Orders tab, you can write new orders and view existing orders for the selected patient. CPRS lets you choose from the following methods of sorting the orders that are displayed:

- Active Orders (includes pending and recent activity)
- Current Orders (includes active and pending)
- Expiring Orders
- Unsigned Orders
- Custom Order List...

All of these options are under the View menu. If you choose one of the first four options, CPRS immediately sorts the list to show the orders in that category. If you choose Custom Order List..., you can make the list of orders very specific. For example, you can view orders from a selected service only. When the Orders tab is displaying only some of the orders, an icon appears below the Postings button on the right side of the dialog. The icon is of a pair of hands covering a sheet of paper and indicates that the user is not seeing all of the orders for the selected patient.



You can also save a view as your default order view by clicking on **View | Save As Default View…**.

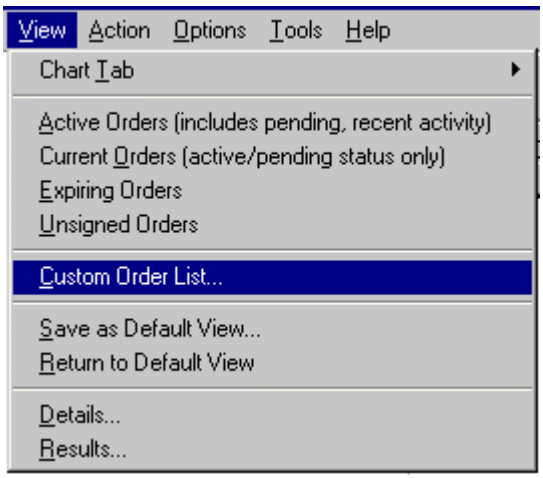
When you view any category of orders, you can quickly get information about each order in the list such as what services the orders are for, the start and stop dates for each order, the name of the provider (or nurse or clerk) that entered the order, and the status of the order.

Changing Views on the Orders tab

Changing the view of the Orders tab allows you to focus the list of orders on one of several criteria. Focusing the list will speed up the selection process.

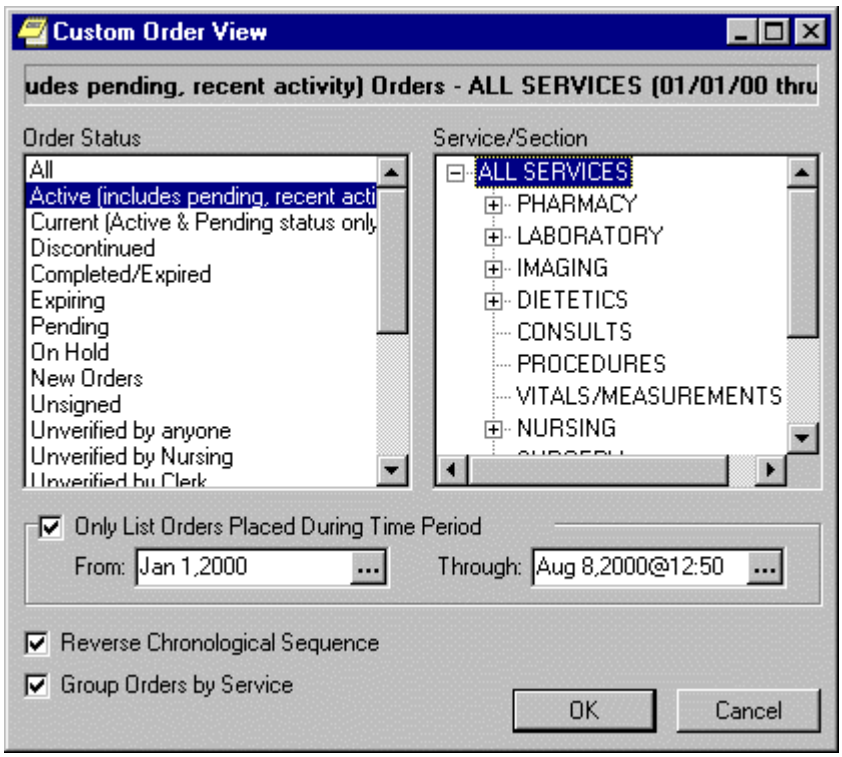
You may change the Orders List view to only include the following problems:

- Active Orders (includes pending and recent activity)
- Current Orders (includes only active and pending orders)
- Expiring Orders
- Unsigned Orders



To change the view, click on the View menu and select the desired list items. You may also double-click on Active Orders in the Orders Sheet field to access that list.

You may select the Custom Order List… option on the menu to further focus the list of orders you wish to have displayed. From the Custom Order View dialog, you may choose to display orders by any combination of Order Status, Service/Section, and date range.



How to Write Orders

With CPRS, you can write orders for medications, consults, lab tests, and so on. You place orders from the orders tab, where you can also view the existing orders.

With CPRS, you can enter orders to be active immediately or enter delayed orders that will become active when the selected patient is admitted, transferred, or discharged. You choose this by selecting the appropriate order sheet (Active, Admit, Transfer, or Discharge) from the Order Sheet field on the upper left corner of the Orders tab.

Once you have selected the appropriate order sheet, you can select an order type from the Write Orders list box, and a new dialog specific to that type of order appears.

CPRS supports Quick Orders and Order Sets. Quick Orders allow the user to enter common or standard orders without going through all of the steps. Quick Orders are set up in advance and then selected a list. Quick Orders are ones that physicians have determined to be their most commonly ordered items and have standard collection times, routes, and other conditions. Order Sets are collections of related orders or Quick Orders, (such as Admission Orders or Pre-Op Orders).

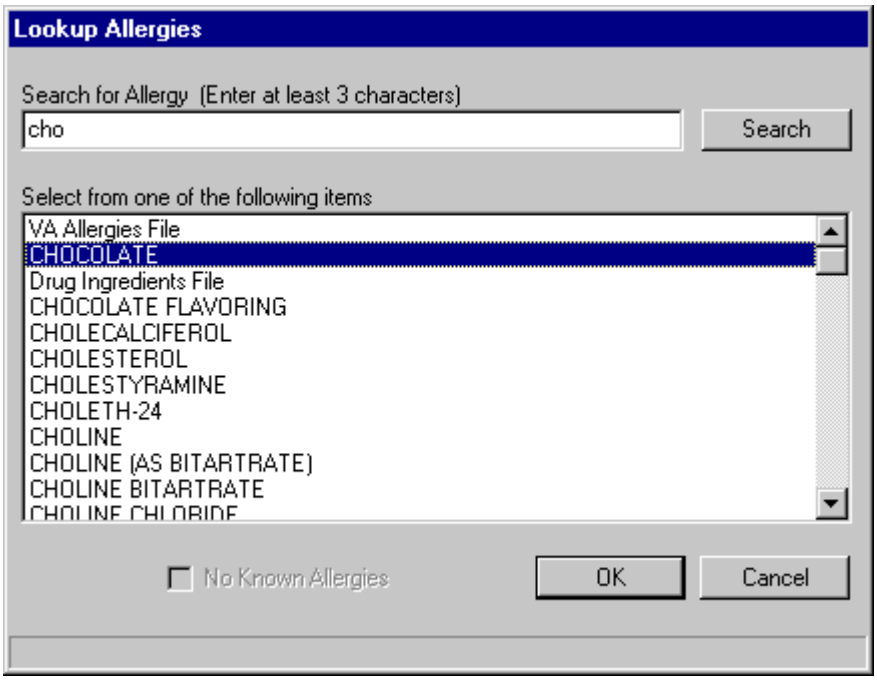
As you specify the order conditions, the order text is displayed in a text field on the ordering dialog, allowing you a way to quickly check your order before you choose Accept Order.

Order checks are performed on all orders when you click Accept Order and before you sign the order to identify duplicate orders, order contraindications, and for other conditions. If the order checks find any of these conditions, you can review them and decide whether to continue placing the order, change it, or cancel it.

Allergies

You can enter allergies when you enter patient orders. After entering one or more allergies, CPRS includes the allergies automatically in its order checks.

To enter an assessment of "no known allergies," see Entering "No Known Allergies."



You can review a patient's current allergies in several places:

- On the Cover Sheet, under Allergies / Adverse Reactions
- From any other tab, click the Postings button if it shows the letter "A"
- On the Orders tab under the "Allergy" service
- On the Enter Allergy Information dialog, click the Current button

To enter an allergy, follow these steps:

1. Click the Orders tab.
2. In the Write Orders list box, click Allergies.
3. In the dialog that appears, select the causative agent. You may type the word or part of the word (a minimum of three characters is required) you are searching for and click Search. In the list that appears, click the causative agent and click OK.

Note: If you need to select a different causative agent, click the button with three dots on it to bring up the search dialog again.

4. In the new dialog that appears, select the reaction type.
5. Enter a reaction date and time if different than now.
6. Select whether this is an observed or historical allergy.
7. If it is a historical allergy, skip to step 9. If this is an observed allergy, select a severity.
8. Select the signs or symptoms of the reaction.

Note: A date/time dialog will appear each time you select a sign or symptom to record when it was observed. You can enter multiple symptoms or signs. To remove a symptom or sign, click on it in the Selected Symptoms box.

9. Enter a comment if desired.

10. Click OK.

No Known Allergies

These steps apply if you do not have a quick order for entering "no known allergies." To enter an assessment of "no known allergies," use these steps:

1. Click the Orders tab.

2. Under Write Orders, click the appropriate order dialog (such as Allergies).

3. When the Lookup Allergies dialog appears, click **Cancel**.

4. In the upper left of the Enter Allergy Information dialog, click the box by **No Known Allergies**.

5. Click **Accept**.

Consults

Consults are requests from one clinician to a hospital service or specialty for a procedure or other service. The Consults process involves the following steps, not all taken by the same individual or service:

1. The clinician orders a consult. While in a patient's CPRS medical record, a clinician enters an order for a consultation or procedure. The ordering clinician may first have to enter Encounter Information.

2. The consult service receives an alert and a printed SF 513 report. The receiving service can then accept the consult, forward it to another service, or send it back to the originating clinician for more information.

3. The consult service accepts or rejects the consult request. The service can accept, discontinue or cancel the consult. Cancelled consults can be edited and resubmitted by the ordering clinician. A consult service clinician sees the patient.

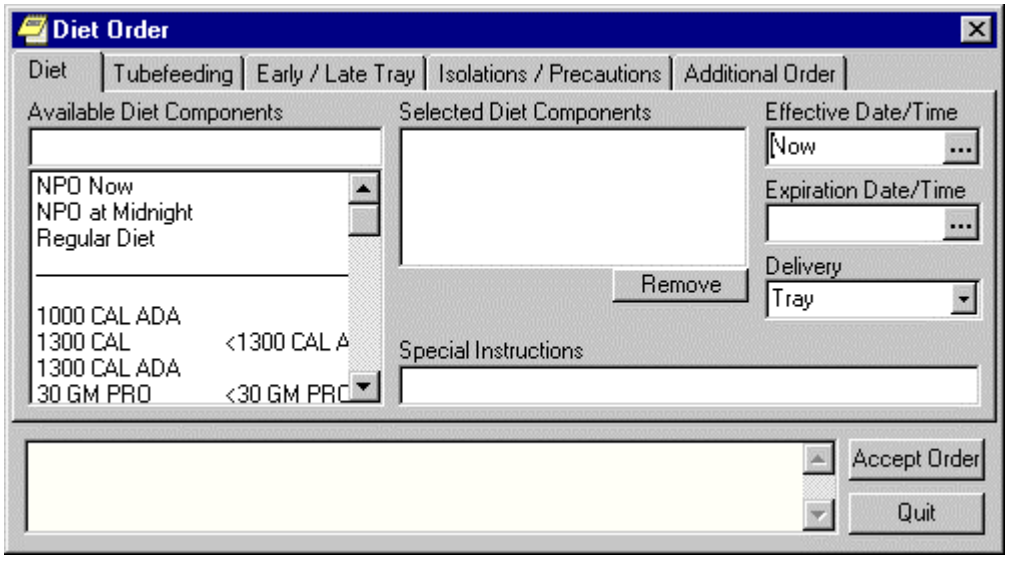
4. The consult service enters results and comments. Resulting is primarily done using the Text Integration Utility (TIU).

5. The originating clinician receives an alert that the consult is complete. The results can now be examined and further action taken on behalf of the patient.

6. The Consult Report (SF 513) becomes part of the patient's medical record. A hard copy can be filed and the electronic copy is on line for paperless access.

Diet

You can order several different kinds of diets from CPRS. The Diet Order dialog shown below has five tabs that offer different types of diet orders. The information you enter on each tab will create a separate order.



For instructions on how to write each kind of diet order, review the following procedure.

1. Click the Orders tab.
2. Click Diet in the Write Orders list box.

Note: The Encounter Information dialog appears if no encounter information has been entered.

3. In the Diet tab, pick a diet from the Available Diet Components list box (Quick Orders are at the top of the list).
4. If you want the order to have the current date and time, go to step 5. Otherwise, enter the Effective Date/Time using the following steps:
   a. Click the button under Effective Date/Time.
   b. Choose the date. Arrows to the right and left of the month allow you to change the month. You then click on the desired day in the calendar shown.
   c. Choose a time. You can click on the hour and the minutes, choose Now, or choose midnight. Click OK.
5. Enter the Expiration Date/Time (use sub-steps a-c in step 4above).
6. Select Delivery method from the drop-down list under delivery.
7. Type in (free text) any special instructions.
8. Click **Accept Order**.
9. Click **Quit**.

Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

You can also copy these orders to the Discharge Orders box.

IV Fluids

To order IV fluids, follow these steps:

1. Click the Orders tab.
2. Click IV Fluids in the Write Orders list box.

Note: The Encounter Information dialog appears if no encounter information has been entered.

3. On the Solution tab, locate and click the solution you want.
4. Enter an infusion rate (free text) in ml/hr or text@labels per day.
5. Choose a priority: Routine, ASAP or STAT.
6. Enter a comment, if desired.
7. Select an additive, if desired (If no additive is desired, go to step 12.)
8. Click the Additive tab.
9. Locate and click the additive you want.
10. Enter an infusion rate (free text) in ml/hr or text@labels per day.
11. Choose a priority: Routine, ASAP or STAT.
12. Enter a comment if desired.
13. Click **Accept Order**.
14. When finished, click **Quit**.

Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Lab Tests

To place an order for a lab test, do the following:

1. Click the Orders tab.
2. Click Lab Tests in the Write Orders box.

Note: The Encounter Information dialog appears if no encounter information has been entered.

3. Locate and click the desired lab test in the Available Lab Tests list box.
4. If desired, change the default values for collection sample type, specimen type, and urgency (if you cannot change a default, the text to the right will be gray instead of black).
5. Select the collection time (today or tomorrow) and the frequency.
6. Enter the number of days that specimens should be taken.
7. Indicate whether you want to send the patient to the lab using the check box.
8. Click **Accept Order**.
9. When finished, click **Quit**.

Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Inpatient Meds

To write a new Inpatient Medications order, use these steps:

1. From the Medications screen, select **Action | New Medication**.

From the Orders tab, Click Meds, and then select Inpatient in the Write Orders box.

Note: If no encounter information has been entered, the Encounter Information dialog appears. A preliminary order check is done and a dialog may appear to provide you with pertinent information.

2. Locate and click on the desired medication in the Medication list box.

3. Locate and click the drug to be dispensed from the Dispense Drug list.

Note: For order checking to work correctly, you must enter the dispense drug.

4. Enter or select Dosage, Route, Schedule, and Priority from the boxes of the ordering dialog that appears.

Note: If you do not complete the mandatory items or if the information is incorrect, CPRS sends a message that tells you that the information is incorrect and shows you the correct type of response.

5. Add comments, if desired.

6. Click **Accept Order**.

7. Enter another medication order or click **Quit**.

Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Outpatient Meds

Outpatient meds can be written as simples doses or complex doses. To write a new Outpatient Medications order, use these steps:

Simple Dose

To write a simple dose of a new Outpatient Medications order, use these steps:

1. Click the Orders tab.

2. Click Meds, Outpatient in the Write Orders list box.

Note: If no encounter information has been entered, the Encounter Information dialog appears. Also, a preliminary order check is done and a dialog may appear to provide you with pertinent information.

3. Locate and click the medication in the list box by typing the first few letters in the name and then scrolling to find it (or simply scroll to find the name) and then click it.

4. Locate and click the form of the drug that should be dispensed from the Dispense Drug list.

5. Enter the number of tablets, the amount of liquid suspension, etc. that the patient should take.

6. Select values for the Route and Schedule fields.

Complex Dose

To write a new Outpatient Medications order, use these steps:

1. Click the Orders tab.

2. Click Meds, Outpatient in the Write Orders list box.

Note: If no encounter information has been entered, the Encounter Information dialog appears. Also, a preliminary order check is done and a dialog may appear to provide you with pertinent information.

3. Locate and click the medication in the list box by typing the first few letters in the name and then scrolling to find it (or simply scroll to find the name) and then click it.
4. Locate and click the form of the drug that should be dispensed from the Dispense Drug list.
5. Enter the number of tablets, the amount of liquid suspension, etc. that the patient should take.
6. Select values for the Route and Schedule fields.
7. Select the other fields Pick Up, Service Connection, Priority, and Refills using the same technique as in step 3.
8. You can also add a comment if desired.
9. Click **Accept Order**.

If you are finished ordering outpatient medications, click **Quit**.

Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Procedures

To order a procedure, use these steps:

1. Click the Orders tab.
2. Click Procedure in the Write Orders list box.

Note: The Encounter Information dialog appears if no encounter information has been entered.

3. Locate and click the desired procedure in the Procedure list box.
4. Enter the reason for the procedure.
5. Select whether the patient is an inpatient or outpatient.
6. Select the Urgency, Place of Consultation, to whose attention you are sending it, and the Provisional Diagnosis.
7. Click **Accept Order**.
8. When finished, click **Quit**.

Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Radiology and Imaging

To order any type of imaging, such as x-ray or a nuclear medicine exam or procedure, follow these steps:

1. Click the Orders tab.
2. Select Imaging in the Write Orders list box.

Note: The Encounter Information dialog appears if no encounter information has been entered.

3. Click the desired imaging type in the Imaging Type list box.
4. Locate and click the desired procedure in the Imaging Procedure list box.
5. Select the appropriate modifiers from the Available Modifiers list.

Note: The modifiers are shown in a field to the left of the Available Modifiers list. If you need to remove a modifier that you have selected, click the modifier, then click Remove.

6. Select the appropriate criteria from the dialog's drop-down lists: Requested Date, Urgency, Transport, Category, and Submit To.
7. Click **Accept Order**.
8. When finished, click **Quit**.

Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Lab Tests

To place an order for a lab test, do the following:

1. Click the Orders tab.
2. Click Lab Tests in the Write Orders box.

Note: The Encounter Information dialog appears if no encounter information has been entered.

3. Locate and click the desired lab test in the Available Lab Tests list box.
4. If desired, change the default values for collection sample type, specimen type, and urgency. (If you cannot change a default, the text to the right will be gray instead of black).
5. Select the collection time (today or tomorrow) and the frequency.
6. Enter the number of days that specimens should be taken.
7. Indicate whether you want to send the patient to the lab using the check box.
8. Click **Accept Order**.
9. When finished, click **Quit**.

Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Vitals

You can enter Vitals information into CPRS from the Cover Sheet. The Cover Sheet displays the patient's most recent vitals information in the lower central part of the Cover Sheet.

To enter a patient's vitals information, follow these steps:

1. Click on a value in the Cover Sheet's Vitals area.
2. Click Enter Vitals in the upper left corner of the dialog that appears.

Note: If the visit has not been defined, the Visit Selection dialog appears. You must choose either a previous visit or define a new visit to enter the vitals.

3. If necessary, enter the encounter information and click OK.

Note: The Enter Vitals for - Patient Name (Patient Name will be replaced with the patient's name, such as John Doe) dialog appears. You will enter the vitals information into this dialog's fields.

4. Enter the desired information.

Note: You can change the temperature, weight, and height units. To do this, you click on the drop-down list arrow and select the units you want.

5. Click **OK** when finished.

6. When you are done viewing the patient's vitals, click on the close box (with the "X" on it) in the dialog's upper right corner.

Event-Delayed Orders

Some orders can also be placed as event-delayed orders. With CPRS, you can place orders that will only become active when a certain event, such as an admission occurs.

For outpatients, admission is usually the only event needed. For inpatients, you can have orders that become active on admission, transfer, or discharge.

You can also copy existing orders to event-delayed orders.

To place an event-delayed order, use the following steps:

1. Click the Orders tab.

2. In the Order Sheet list box on the left of the Orders tab, click the event, such as Admit, Transfer or Discharge, which will activate the order you will enter.

3. Enter the order as you normally would.

Copying Existing Orders

With CPRS, you can copy an existing order to create a new order.

The copied order can be released immediately or you can set it to be delayed until an event, such as admission, transfer, or discharge, occurs.

To copy an order, use these steps:

1. Click the Orders tab.

2. Select the order or orders you want to copy. Hold down the CTRL key and click on the desired orders to select more than one order. Hold down the SHIFT key and click on the first and last desired orders to select a range of orders.

3. Select **Action | Copy to New Order** or right-click on a selected order and select Copy to New Order.

4. In the dialog that appears, click whether you want the orders released immediately or if they should be delayed.

5. If you chose Release Copied Orders Immediately, skip to step 7. If you chose Delay Release of Copied Orders, choose the event under that choice that should release the orders.

6. If necessary, choose the specialty or admission location.
7. If the order does not require changes, click Accept. If the order requires changes, click Edit, make the changes, and click Accept.
8. Repeat steps 6 and 7 as needed for the orders selected.
9. When finished, you can sign the orders for wait until later.

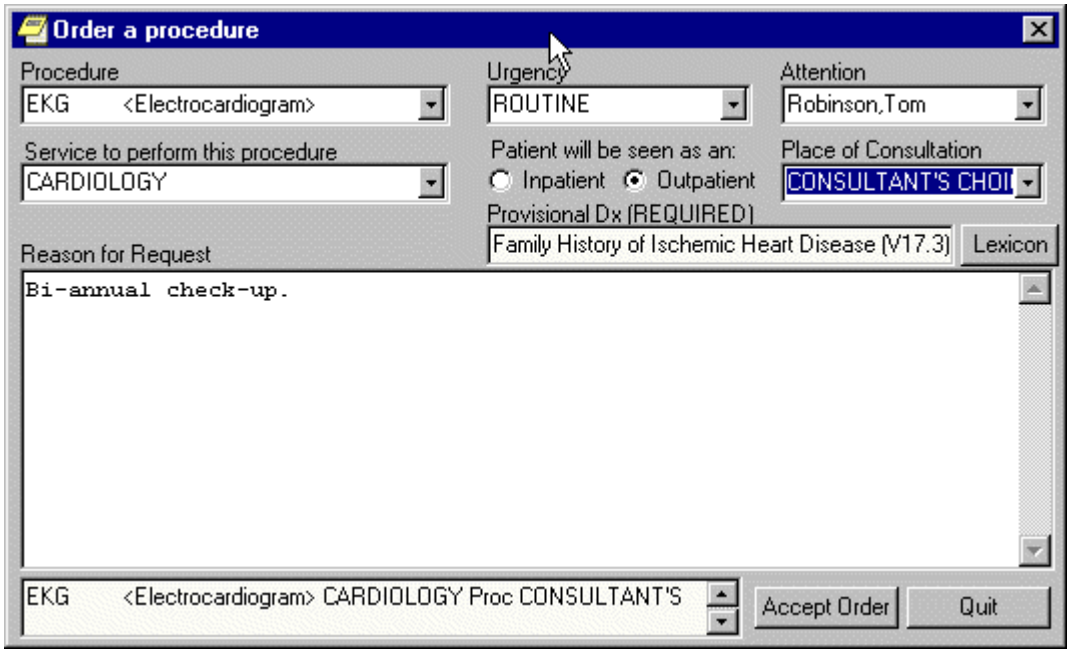
Ordering Actions

The following actions are available from the Action menu on the Orders tab (or by right-clicking). If an action is grayed-out, you can't perform that action on this order.

- Change
- Discontinue / Cancel
- Hold
- Release Hold
- Renew
- Flag
- Unflag
- Acknowledge
- Release without Signature
- Sign

New Procedure from the Orders Tab

1. Select the Orders tab.
2. In the Write Orders field, click on Procedure.
3. If the Provider & Location for Current Activities dialog opens, complete contact information.
4. Select a procedure. The Order a Procedure dialog opens.



5. Type in the reason for the procedure request I the Reason for Request text field.
6. Make sure the following fields show the correct information. Make changes as necessary:
   - Service to perform this procedure
   - Patient will be seen as an Inpatient/Outpatient
   - Urgency
   - Place of Consultation
   - Attention
   - Provisional Diagnosis (may be require depending on the procedure)
7. Click **Accept Order**.
8. If there are no other procedure orders for this patient, click **Quit**.

You may sign the procedure request now or later.

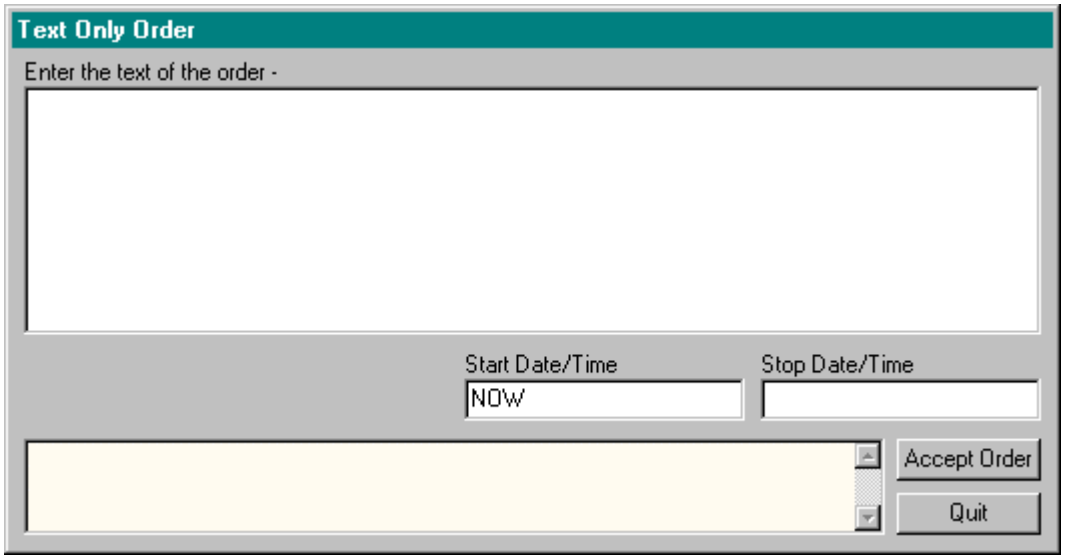
Text Orders

Parameters, Activity, Patient Care, and Free Text orders are different kinds of orders that are placed for nursing and ward staff to take action on. They print only at the patient's ward/location, and are not transmitted electronically to be completed by other services.

Examples of these various kinds of nursing orders are:

Order Type	Order
Parameters	Vital signs
Activity	Bed rest, ambulate, up in chair
Patient Care	Skin and wound care, drains, hemodynamics
Free text	Immunizations

Predefined nursing orders (quick orders) may be available under various sub-menus. Selecting the Text Only option from the Order Screen may also be used to compose nursing orders. These orders require the ward staff to take action to complete the request.



Ordering a New Consult from Orders tab

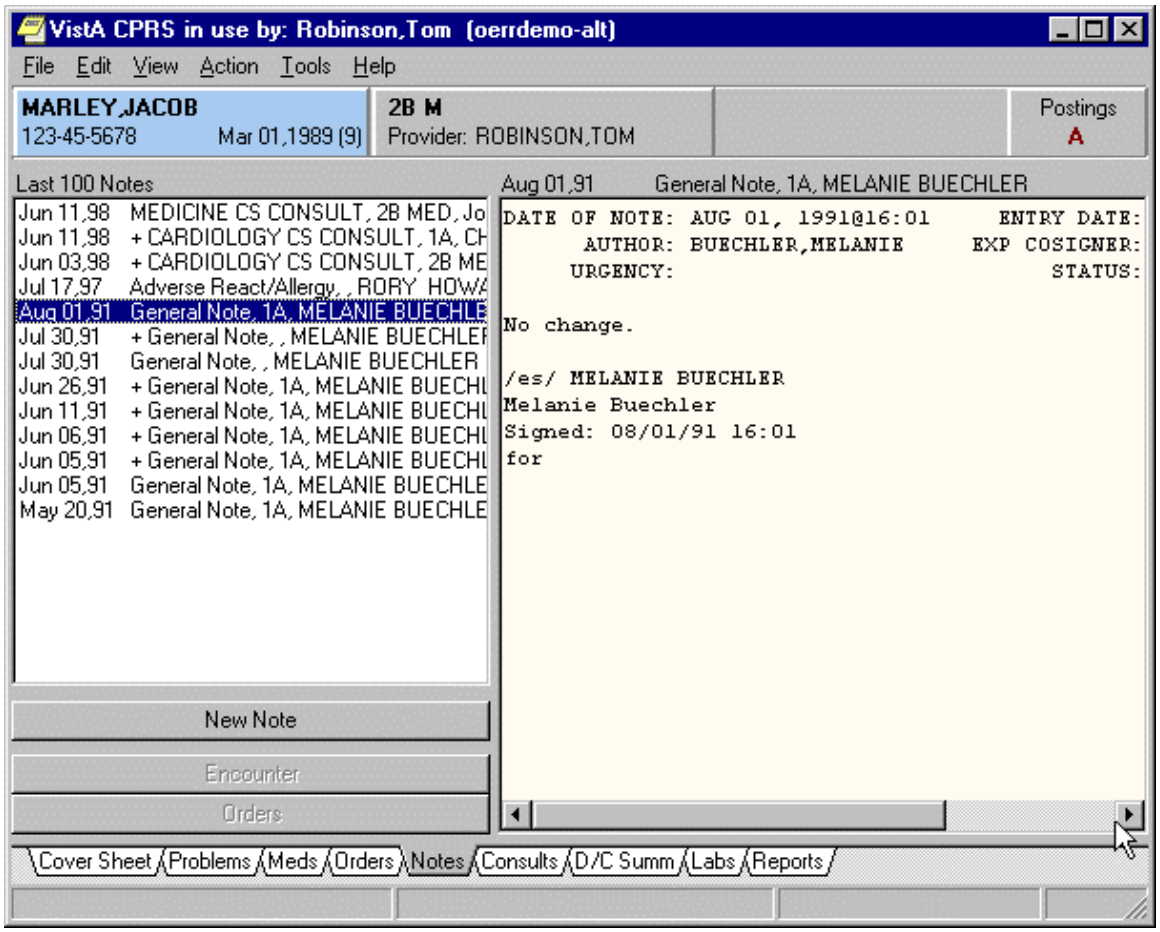
1. Select the Orders tab.
2. In the Write Orders dialog, select Consult.
3. If the Provider & Location for Current Activities dialog opens, complete the contact information.
4. Select a type of consult from the list in Consult to Service/Specialty field.
5. The reason for the consult is automatically generated in the Reason for Consult field.
6. Make sure the following fields show the correct information:
   - Consult to Service/Specialty
   - Patient will be seen as an
   - Urgency
   - Place of Consultation
   - Attention
   - Provisional Diagnosis
7. Click **Accept Order**.
8. If there are no other procedure orders for this patient, click **Quit**.
9. You may sign the consult now or later.

Notes

The Notes tab gives you quick access to the Progress Notes for a specific patient. On the left, you can see a list of the 100 most recent Progress Notes. Hold the mouse pointer over a listing to see the entire line of the listing. The Progress note that is highlighted is displayed on the right.

Click on the View and Action menus to see the available options.

You can also click the New Note button to create a Progress Note. You may also have to enter encounter information if the visit has not been defined.



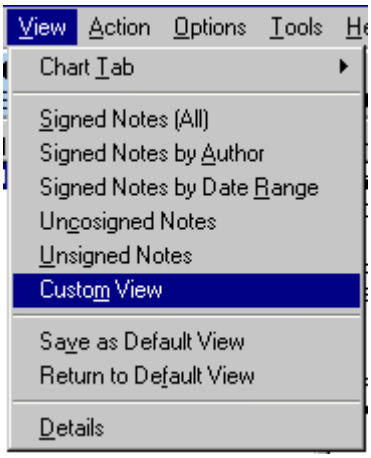
Changing Views on the Notes tab

Changing the view of the Notes tab allows you to focus the list of notes on one of several criteria. Focusing the list will speed up the selection process.

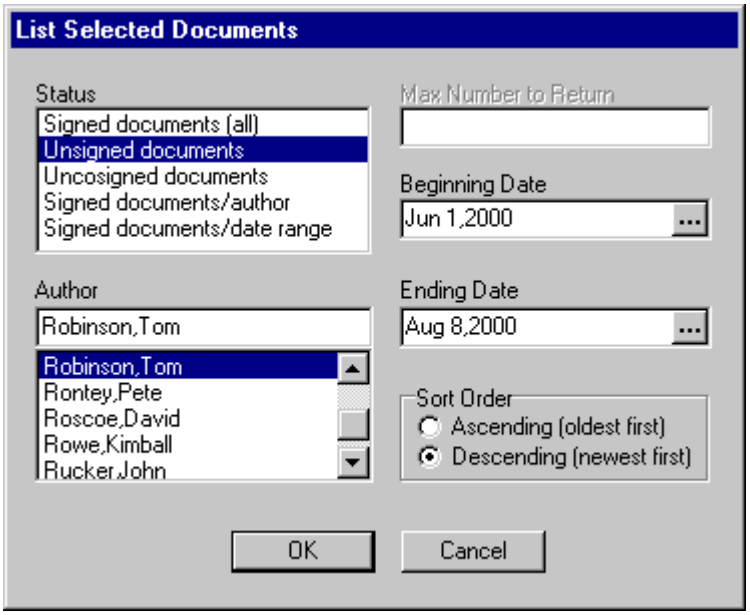
You may change the Orders List view to only include the following problems:

- Signed Notes (All)
- Signed Notes by Author
- Signed Notes by Date Range
- Uncosigned Notes
- Unsigned Notes

To change the view, click on View on the menu and select the desired list items.



You may select the Custom View option on the menu to further focus the list of notes you wish to have displayed. From the List Selected Documents dialog, you may choose to display notes by any combination of Status, Author, and date range.



Encounter Information

CPRS has two kinds of encounter information: visit information and encounter form data.

For each visit (or telephone call) with a patient, you need to enter the provider, location, date, and time. CPRS requires this information before you can place orders, write notes, add to the problem list, and so on.

To receive workload credit, you must enter the encounter form data, including the following information, for each encounter:

- Service connection
- Provider name
- Location

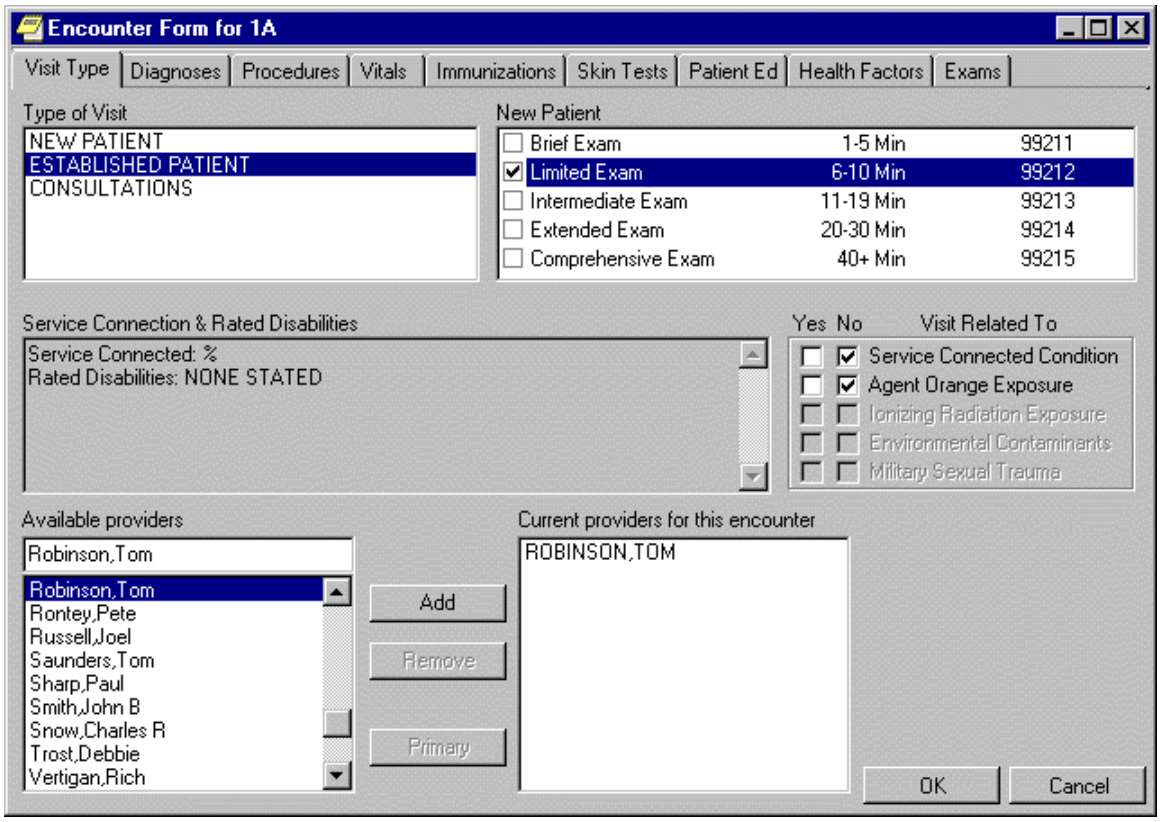
- Date
- Diagnosis
- Procedure
- Visit Information

CPRS shows the encounter provider and location for the visit on the Visit Encounter box, identified in the graphic by the pointer. You can access this box from any chart tab.

If a provider or location has not been assigned, CPRS will prompt you for this information when you try to enter progress notes, create orders, and perform other tasks.

Encounter Form Data

For workload credit and to gather other information, you enter encounter form data when you create a progress note, complete a consult, or write a discharge summary. When you create one of these documents, an Encounter button appears. Click this button to bring up the Encounter Frame or you will be prompted for encounter information when you try to sign the note or exit the current patient's chart.



The Encounter Frame has eight tabs:

- Visit Type
- Diagnoses
- Procedures
- Vitals
- Immunizations

- Skin Tests
- Patient Education
- Health Factors
- Exams
- Global Assessment of Functioning (GAF) (The GAF tab is only available if specific Mental Health patches are installed and if the location is a mental health clinic.)

Your site defines forms from Automated Information Collection System (AICS) application to be used with the Encounter Frame. Once your site has defined the necessary forms and associated them with the Encounter Frame, each tab has a number of general categories on the left. When you click on a general category on the left, the corresponding items appear in the list box on the right.

For example, the Visit Type tab might have New Patient, Established Patient, and so on listed in the left list box. The list box on the right would have check boxes for the different types of patient appointments, such as 15 minutes, 30 minutes, 45 minutes, and so on.

Even if you don't have the form defined yet, you can click on the Other button to get a list of choices that are active on your system.

With the forms defined and associated with the Encounter Frame, you can use the Encounter Frame just like a paper form, clicking the appropriate tab, category, and check boxes to mark items or clicking Other and selecting the appropriate choice.

If these forms have not been defined, ask your Clinical Coordinator about it. When the forms have been created, you can quickly enter patient care encounter data.

Entering Encounter Form Data

To receive workload credit, enter encounter form data when you create a new Progress Note, complete a Consult, or write a Discharge Summary for the selected patient.

Note: Once a note, summary, or consult has been completed, you can only change encounter information directly through Patient Care Encounter (PCE.)

To enter encounter form data, follow these steps:

1. Click the appropriate tab: Notes, Consults, or D/C Summ.
2. Click **New Note**, **New Summary** or select **Action | Consult Results....**
3. Type in a title for the note or summary or select one from the list.
4. Click **Encounter**.
5. Click the tab where you want to enter information (Type of Visit, where you can also enter the primary and secondary providers, Diagnoses, where you can have diagnoses automatically be added to the Problem List, Procedures, Vitals, Immunizations, Skin Tests, Patient Ed., Health Factors, or Exams).
6. Click the appropriate category in the list box on the left and then click the check boxes by the appropriate items in the list box on the right. If the section name you want is not shown or the list boxes are empty, use the search feature. To search, click on the Other <Tab Name>. (Each tab's button will be labeled differently.) Locate and double-click the needed item. Some tabs have a simple list to choose from. Diagnoses and Procedures have a search function. On these

tabs, you need to enter the beginning of a term and click Search before double-clicking.

Note: The Type of Visit and Vitals tabs are different. Type of Visit has no button, and Vitals has a Historical Vitals Details button that brings up a dialog containing a graph and a listing of past vitals taken.

7. Enter any additional information as needed. Several tabs have additional features, such as drop-down lists for results of exams, severity of problems, and so on.

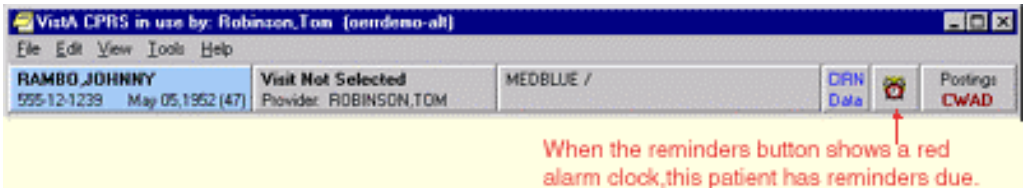
8. Fill in information for other tabs as needed by repeating steps 2-6.

9. When finished, click **OK**.

Clinical Reminders

There are three main ways you can know that patient has reminders:

- The reminders button near the top right of the CPRS form may have one of five icons on it. If you click this button, you bring up the dialog that shows a reminders tree view.



- The coversheet has an area specifically for reminders.

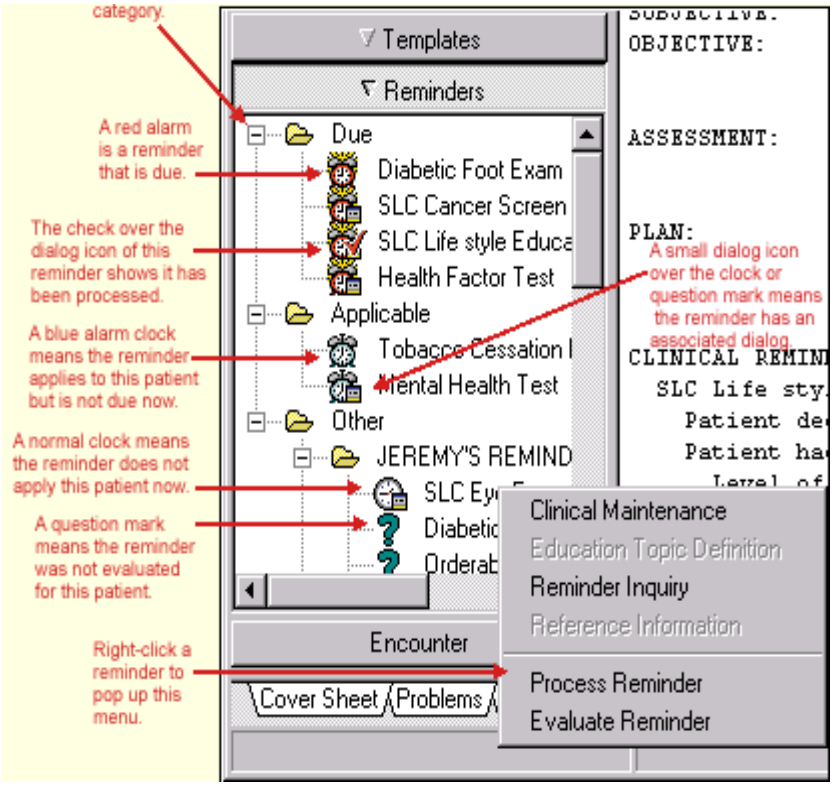
- After you begin a new progress note, you can open a reminders drawer to check on the reminders for this patient. If you click the reminders drawer, you bring up the dialog that shows a tree view of due, applicable, and other reminders.

The Reminders Drawer

After you begin a new note, you will see the Reminders drawer. Click to open the drawer and see a tree view of reminders that are due, applicable, and other reminders as shown here. The Due category is automatically expanded when you open the Reminders drawer, while the Applicable and Other categories are not.

Note: Before you can process a reminder, the CAC or someone else must create a dialog in a similar position at your site. A dialog image over the clock or question mark icon shows that a reminder has an associated dialog.

After you process a reminder but before you reevaluate it, a check is placed over the reminder to show it has been processed. If you evaluate the reminder again, the reminder should be moved down to applicable but not due.



Click on a reminder to bring up the Reminders Processing dialog and process a reminder.

Right-click on a reminder to get the following options:

- Clinical Maintenance - shows the possible resolutions and the findings associated with the reminder
- Education topic definition - may list the education topics that have been defined for a reminder. You can select a topic to view the desired education outcome and any standards.
- Reminder Inquiry - will show the reminder definition describing which patients are selected for this reminder
- Reference Information - can list web sites with additional information.

Each of these options will bring up a window. When you are finished with the window, click Close. For more information on Clinical Reminders, refer to the *Clinical Reminders Manager Manual* and *Clinical Reminders Clinician Guide.*

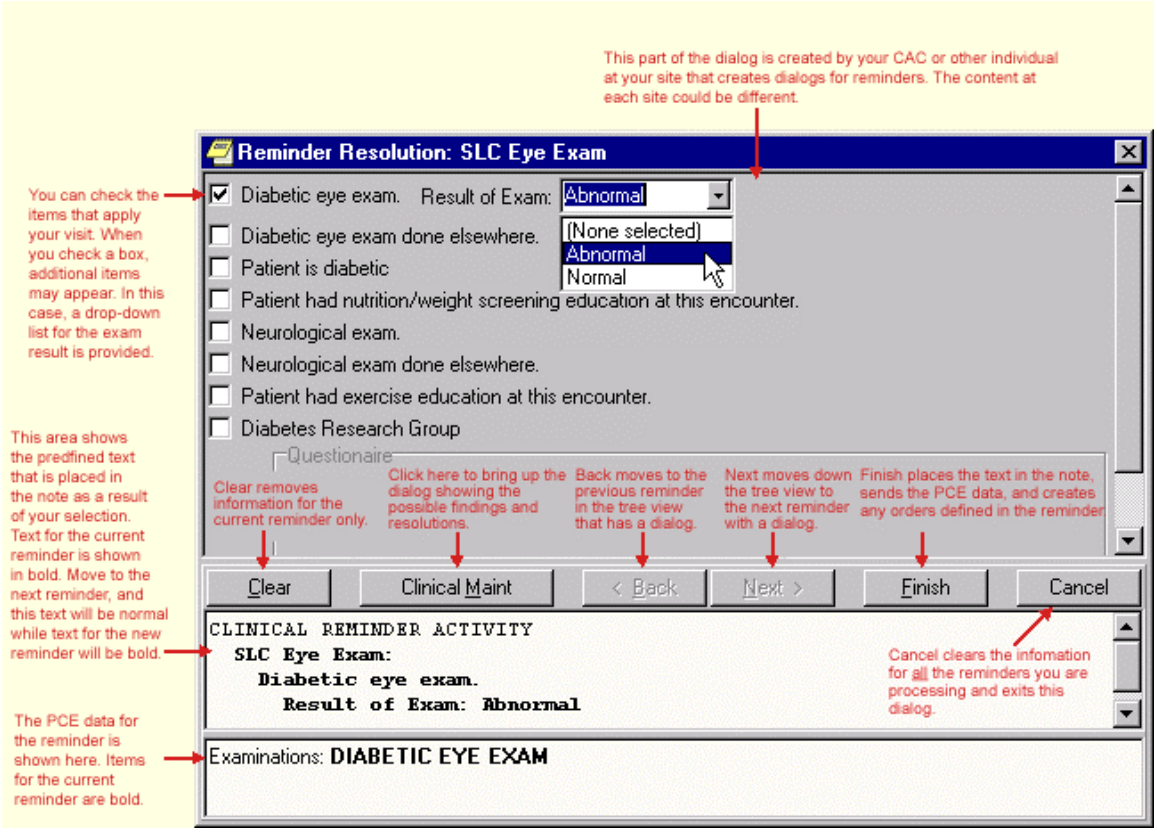
Reminders Processing

If you process reminders, you will process your reminders using the Reminders Processing dialog. It shows the possible activities that can occur during a visit and that can satisfy the reminder. You may need to enter additional information.

When you check an item, it may expand to enable entry of more detailed information, such as dates, locations, test results, etc., or orders that you might often place based on a response. The information depends on how the dialog was created at your site.

When you click a checkbox or item, the associated text that will be placed in the progress note is shown in the area below the buttons. Patient Care Encounter (PCE) data for the item is shown in the area below that.

Text and PCE data for the reminder you are currently processing are in bold.



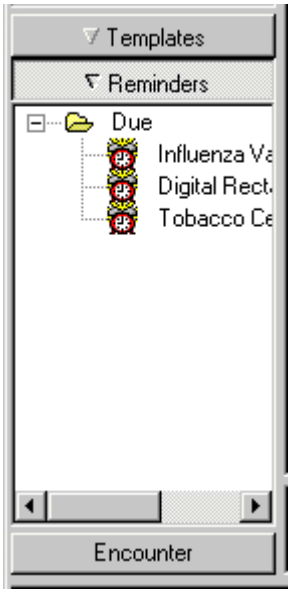
Processing a Reminder

To process a reminder for a patient, complete the following steps:

1. If you have not already, begin a new progress note by clicking the Notes tab, then New Note, and then select a note title. (If prompted, enter the encounter location and provider.)
2. Click the Reminders drawer to open its tree view or click the Reminders button to open a tree view of the reminders for this patient.

3. Click the plus sign to expand the hierarchy where needed and click the reminder you will process. You will then be presented with the dialog for processing reminders.

Note: If you click the Reminders button, you can also choose Action | Process Reminders Due to begin with the first reminder due.



4. Read the choices, click the checkboxes in front of the items that apply to this patient, and enter any additional information requested such as comments, diagnoses, and so forth.
5. When you are finished with this reminder, click another reminder or click Next to move to the next reminder.
6. Repeat steps 4 and 5 as necessary to process the desired reminders.
7. When you have processed all the reminders you want to do at this time, click Finish.
8. Review and finish your progress note and enter any information necessary in order dialogs.

Completing Reminder Processing

After you have entered all the information, you can finish processing the reminders.

When you finish, the following things will happen:

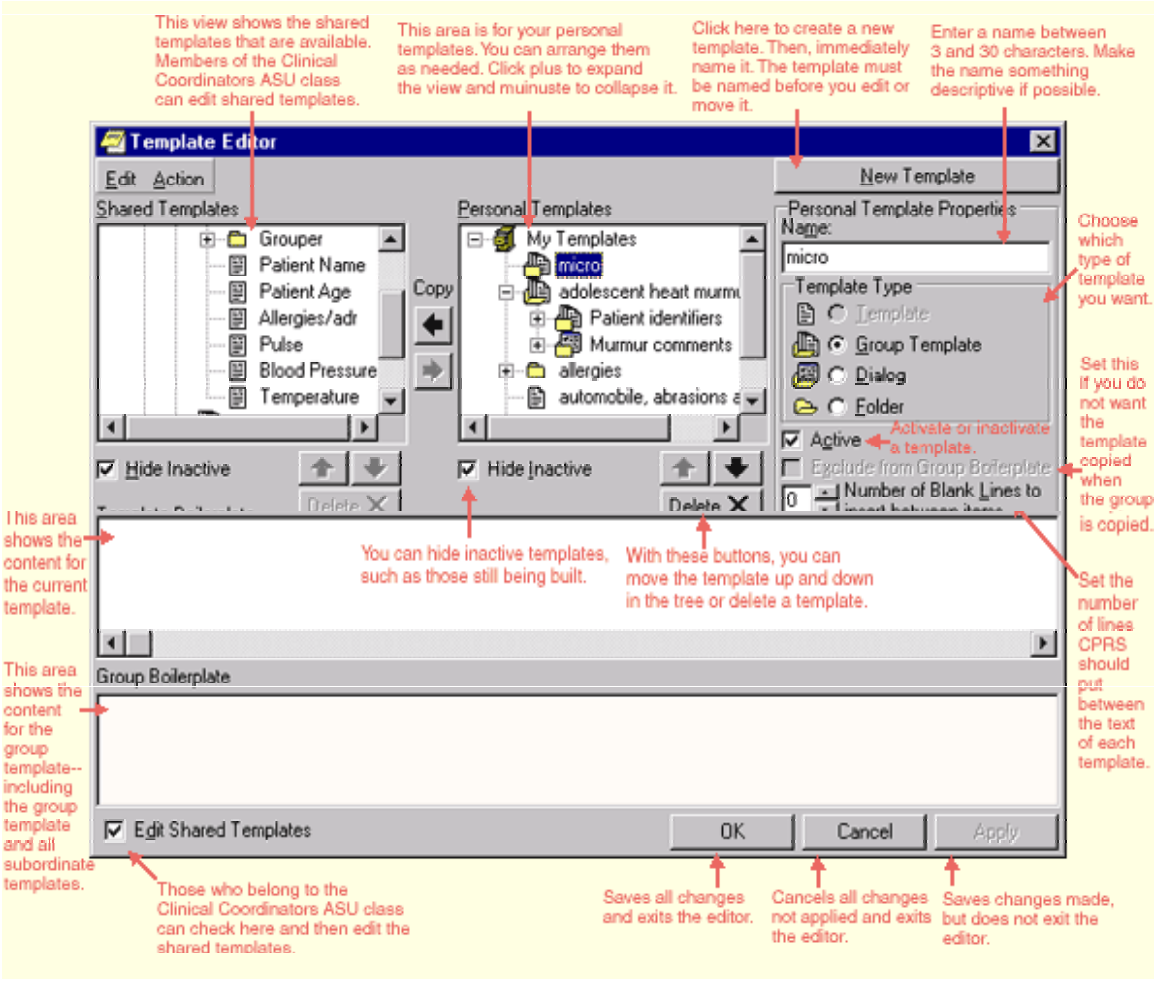
- The predefined text is placed in the note you have begun writing.
- The encounter information to is sent to Patient Care Encounter (PCE) application for storage.
- If there are orders defined in the dialog, it will also create the orders. If the orders require input (if they are not predefined quick orders without prompts), the order dialogs will come up so that you can complete the orders. You will then have to sign any orders that are created.

To finish processing reminders, click **Finish**.

Document Templates

You can create document templates to quickly add commonly used text and Text Integration Utility (TIU) objects when writing or editing Progress Notes, completing Consults, or writing Discharge Summaries. For more information on how to use TIU, refer to the *Text Integration Utility User Manual*.

The Template Editor is shown in the following graphic.



Personal and Shared Templates

You can create and use your own templates or use shared templates that your Clinical Coordinator creates:

Personal templates.

Any user can create personal templates. You can copy and paste text into a template, type in new content, add TIU objects, or begin by copying a shared template and then modifying it as needed. Personal template and folder icons have a folded upper right corner.

Shared templates.

Only members of the Clinical Coordinator Authorization/Subscription Utility (ASU) class can create shared templates. Shared templates are available to all users. Coordinators can copy and paste text into a template, type in new content, add TIU objects, or begin by copying a personal template and then modifying it as needed. In the tree view, shared template and folder icons do not have a folded corner.

Note: When you install CPRS, a copy of all your existing boilerplate titles is placed in the inactive boilerplates folder under shared templates.

Clinical coordinators can arrange the boilerplate titles copied into the shared templates to be used as templates, use them to create new templates, or make them available to users

by moving them out of the inactive folder. You will not see the inactive folder or its templates unless you choose to make the folder active.

(To see the boilerplates folder, clinical coordinators should go into the templates editor, make sure Edit Shared Templates is checked, uncheck Hide Inactive under shared templates, and click the plus sign beside the shared icon.) For more information on boilerplates, refer to the *Text Integration Utility User Manual*.

Types of Templates

When you create templates, you can go directly into the template editor, type in text, and add TIU objects, or if you are in a document and type in something you will use repeatedly, you simply select that text, right-click, select Create New Template, and the editor comes up with the selected text in the editing area. You can create individual templates, group templates, dialog templates, or folders. For more information on creating objects, refer to the *Text Integration Utility User Manual*.

Templates

Templates contain text and TIU objects that you can place in a document.

Group Templates

Group templates contain text and TIU objects and can also contain other templates. If you place a group template in a document, all text and objects in the group template and all the templates it contains (unless they are excluded from the group template) will be placed in the document. You can also expand the view of the group template and place the individual templates it contains in a document one at a time.

Dialog Templates

Dialog templates are like group templates in that they contain other templates. You can place a number of other templates under a dialog template. Then, when you drag the dialog template in your document, a dialog appears that has a checkbox for each template under the Dialog template. The person writing the document can check the items they want and click OK to place them in the note.

Folders

Folders are like folders or directories in a file system. They are used to group and organize templates. You cannot place a folder in a document. It is there to hold templates and help in navigating the template tree view. For example, you might create a folder called "radiology" for templates, group templates, and other folders relating to radiology.

Arranging Templates for Ease of Use

How you arrange your templates will depend on what your specific needs are. However, it may be useful to group similar templates together. You can also use folders to group similar templates, making them easier to find. This organization will be similar to a good directory structure for your workstation. For example, you may want to place all of the pulmonary templates together rather than alphabetizing templates.

By placing those templates together that you will use, you will spend less time moving around the tree to find the template you need.

Using Templates to Create Documents

Once you or your clinical coordinator has created templates, adding them to a document is easy. When you create a new note, a Templates drawer appears. When you click the drawer, it opens to show you the templates that are available.

Group templates and folders will have a plus next to them. Click the plus to expand the tree view and see the templates they contain. Click a minus sign to collapse the tree view, hiding the templates under that item.

When you find the template you want to place in a document, you can drag-and-drop it into the document, double-click it, or right-click and choose Insert Template. The text and objects will appear where the cursor was a few seconds later.

Searching for Templates

You can search for templates by the words in the template name. To search, you right-click in the templates in the editor or in the templates drawer and choose Find Templates. A text field, Find button, and two find options check boxes will appear. Enter the text you want to find and click Find.

Previewing a Template

You can preview a template to see what it will place in your document. To preview a template, right-click on it in the Templates drawer on the Notes tab. Then select Preview Template.

Deleting Document Templates

When you no longer need a template or if you create one by mistake, you can delete it. CPRS will ask you if you want to make the template inactive rather than delete it. To delete a document template, use these steps:

1. Click the Notes, Consults, or D/C Summ tab.
2. Select **Options | Edit Templates** or if the Templates drawer is open, right-click in the drawer, and select Edit Templates.
3. Find the template you want to delete. Click the plus sign next to an item to see the objects under it. Continue until you find the right location.
4. Right-click the template you want to delete and select Delete or click the template you want to delete and then click the delete button under that tree view.
5. Click Yes to confirm the deletion

Creating Personal Document Templates

You can create personal templates consisting of text and TIU objects to speed document creation. You can use the templates to create progress notes, complete consults, and write discharge summaries.

Template

To create a personal document template, use these steps:

1. On the Notes, Consults, or D/C Summ tab, bring up the Template Editor by selecting **Options | Create New Template** or you can save specific text from a document in CPRS as a template, select the text, right-click on it, and then select Copy into New Template.
2. In the Name field under Personal Template Properties, enter a name for the new template. Make the name descriptive of the content for ease of use.
3. Click the template type: Template.
4. Enter the content for the template by copying and pasting from documents outside CPRS, typing in text, and/or inserting TIU objects.

Note: After you enter the content, you can right-click in the Template Boilerplate area to select spell check, grammar check, or Check Boilerplate for Errors, which looks for invalid TIU objects.

5. Place the template where you want it in the tree view. To place it, click the plus sign next to an item to see the objects under it. Then, drag-and-drop the template where you want it in the tree. (Or use arrows below the personal templates tree view.)
6. To save the template, click Apply. To save and exit the editor, click OK.

Note: You do not have to click Apply after each template, but it is recommended because if you click Cancel, you will lose all changes you have made since the last time you clicked Apply or OK.

Group Template

You can create group templates that contain other templates under them. You can then place the entire group template in the note, which will bring in the text and TIU objects from all templates in that group, or expand the tree view in the templates drawer and place the individual templates under the group template in the note.

To create a personal Group Template, use these steps:

1. On the Notes, Consults, or D/C Summ tab, bring up the Template Editor by selecting **Options | Create New Template** or you may save specific text from a document in CPRS as a template, select the text, right-click on it, and then select Copy into New Template.
2. In the Name field under Personal Template Properties, enter a name for the new template. Remember the template name requirements. You should also make the name descriptive of the content for ease of use.
3. Click the template type: Group Template.
4. If desired, enter the text and TIU objects to create content in the main text area of the group template. You can enter content by copying and pasting from documents outside CPRS, typing in text, and/or inserting TIU objects.

Note: After you enter the content, you can right-click in the Template Boilerplate area to select spell check, grammar check, or Check Boilerplate for Errors, which looks for invalid TIU objects.

5. You can also create additional templates under the Group Template that you just created and add content there. You can do that by highlighting the appropriate group template and clicking New Template. Then complete the steps for creating a new template as they are outlined above.

6. Place the template where you want it in the tree view. Click the plus sign next to an item to see the objects under it. Then drag-and-drop the template where you want it in the tree. (Or use arrows below the personal templates tree view.)

7. To save the template, click Apply. To save and exit the editor, click OK.

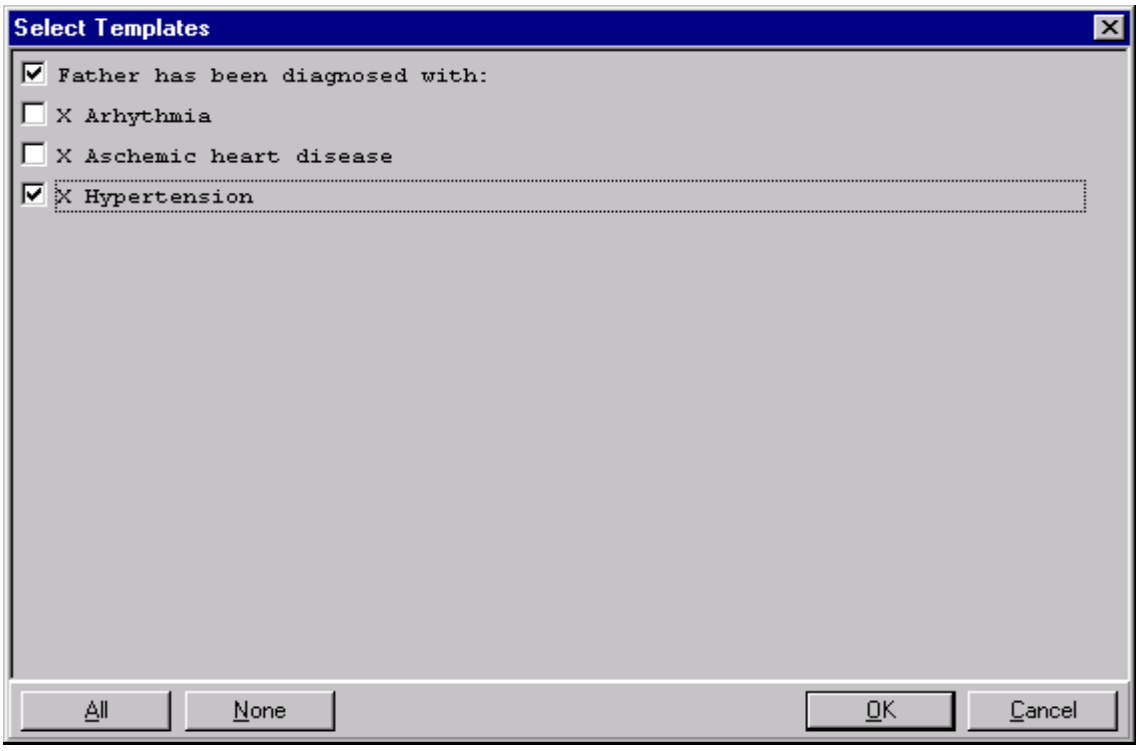
Note: You do not have to click Apply after each template, but it is recommended because if you click Cancel, you will lose all changes you have made since the last time you clicked Apply or OK.

Dialog Template

Dialog templates contain other templates just as group templates do. Each template under a dialog template will have a check box in a dialog when the dialog template is placed in a document.

When a user double-clicks a dialog template or drags it onto the note, a dialog appears. The dialog shows the text for each template preceded by a check box.

The user clicks the box to check which items they want included in the note. The user can choose All or choose None if they need to begin again, and clicks OK when done.



To create a personal Dialog Template, complete these steps:

1. On the Notes, Consults, or D/C Summmary tab, bring up the Template Editor by selecting **Options | Create New Template** or you may save specific text from a document in CPRS as a template, by selecting the text, right-clicking on it, and selecting Copy into New Template.

2. In the Name field under Personal Template Properties, enter a name for the new template. Remember the template name requirements. You should also make the name descriptive of the content for ease of use.

3. Click the template type: Dialog.

4. If desired, enter the text and TIU objects (if desired) to create content in the main text area of the group template. You can enter content by copying and pasting from documents outside CPRS, typing in text, and/or inserting TIU objects.

Note: After you enter the content, you can right-click in the Template Boilerplate area to select spell check, grammar check, or Check Boilerplate for Errors, which looks for invalid TIU objects.

5. You can also create additional templates under the dialog template that you just created and add content there by highlighting the appropriate dialog template and click New Template. Then complete the steps for creating a new template as they are outlined above.

6. Place the template where you want it in the tree view. Click the plus sign next to an item to see the objects under it. Then, drag-and-drop the template where you want it in the tree. (Or use arrows below the personal templates tree view.)

7. To save the template, click Apply. To save and exit the editor, click OK.

Note: You do not have to click Apply after each template, but it is recommended because if you click Cancel, you will lose all changes you have made since the last time you clicked Apply or OK.

Folder

Folders are simply containers that allow you to organize and categorize your templates. For example, you might want to create a folder for templates about diabetes or one about mental health issues.

To create a personal template folder, complete these steps:

1. On the Notes, Consults, or D/C Summ tab, open the Template Editor by selecting **Options | Create New Template** or you may save specific text from a document in CPRS as a template, select the text, right-click on it, and select Copy into New Template.

2. In the Name field under Personal Template Properties, enter a name for the new folder. You should also make the name descriptive of the content for ease of use.

3. Click the template type: Folder.

4. Click and drag the templates that relate to the folder you created.

Note: You do not have to click Apply after each template, but it is recommended because if you click Cancel, you will lose all changes you have made since the last time you clicked Apply or OK.

Consults

Consults are requests from one clinician to a hospital service or specialty for a procedure or other service.

The Consults process involves the following steps, not all taken by the same individual or service:

1. The clinician orders a consult. While in a patient's CPRS medical record, a clinician enters an order for a consultation or procedure. The ordering clinician may first have to enter Encounter Information.
2. The consult service receives an alert and a printed SF 513. The receiving service can then accept the consult, forward it to another service, or send it back to the originating clinician for more information.
3. The consult service accepts or rejects the consult request. To accept the consult, the service uses the receive action. The service can also discontinue or cancel the consult. Cancelled consults can be edited and resubmitted by the ordering clinician. A consult service clinician sees the patient.
4. The consult service enters results and comments. Resulting is primarily done using TIU.
5. The originating clinician receives an alert that the consult is complete. The results can now be examined and further action taken on behalf of the patient.

The SF 513 report becomes part of the patient's medical record. A hard copy can be filed and the electronic copy is on line for paperless access.

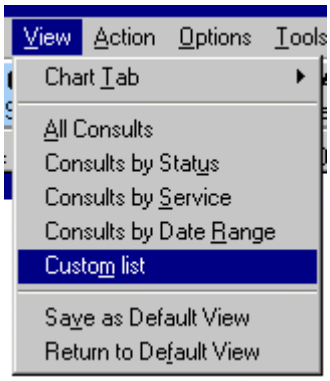
Changing the View on the Consults tab

Changing the view of the Consults tab allows you to focus the list of consults on one of several criteria. Focusing the list will speed up the selection process.

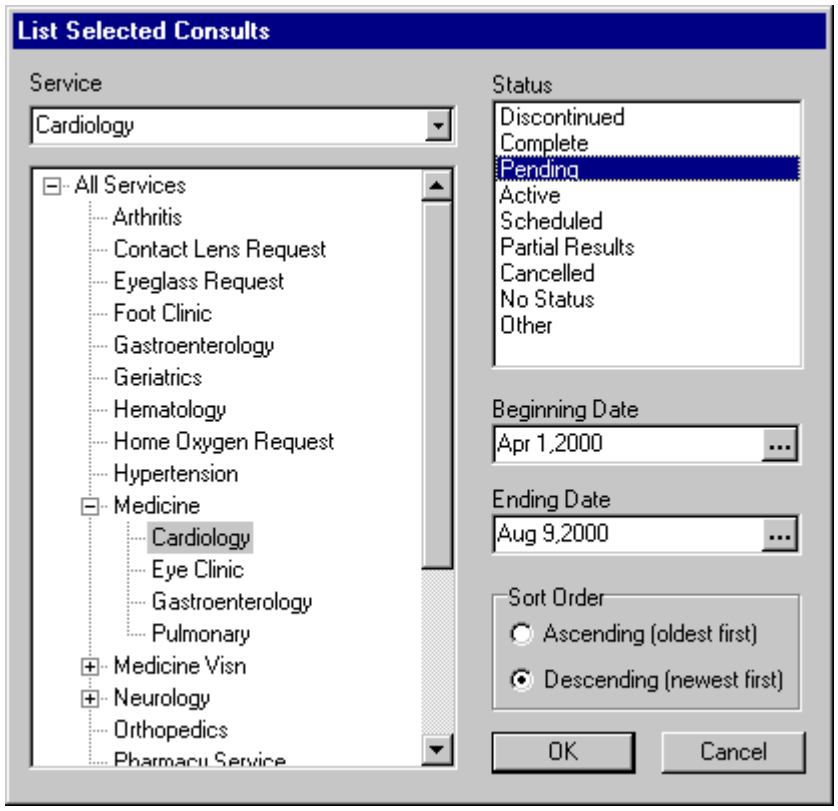
You may change the Consults view to only include the following problems:

- All Consults
- Consults by Status
- Consults by Service
- Consults by Date Range

To change the view, click on View on the menu and select the desired list items.

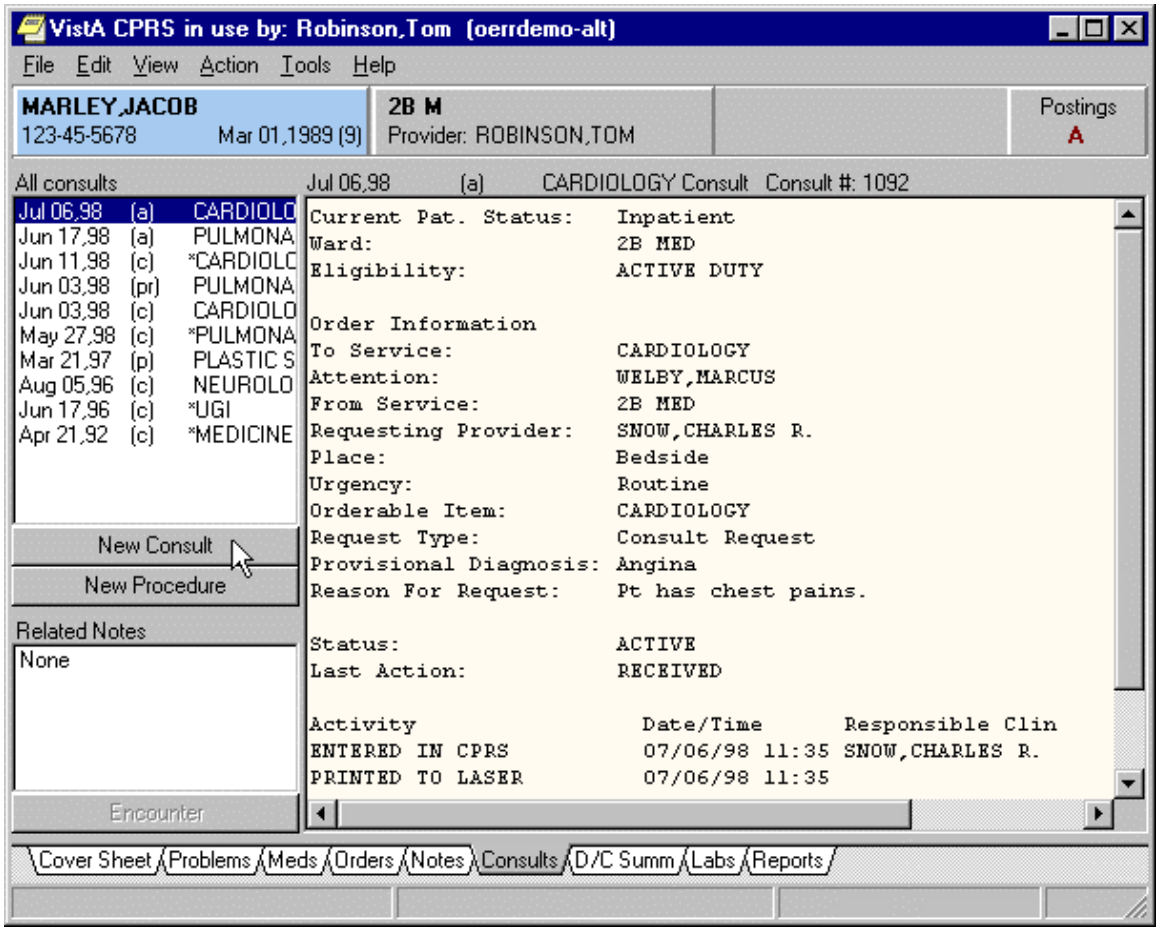


You may select the Custom list option on the menu to further focus the list of notes you wish to have displayed. From the List Selected Consults dialog, you may choose to display consults by any combination of Service, Status, and date range.



Ordering Consults

You can order a consult or procedure from either the Consults or the Orders tab. As you fill in the options, the consult request will be displayed in the text box at the bottom center of the dialog.



Viewing Consults

To view the consults or procedures for the selected patient, use the steps below. When you select a specific consult, you will see an area that lists any notes associated with the consult. You can also click on a note entry to view the full text of the note.

The All Consults list box shows the date, status (p=pending, c=complete, dc=discontinued, and x=cancelled), and title of each consult. An asterisk preceding the title tells you that there are significant findings for that consult.

To view consults, follow these steps:

1. Click the Consults tab.
2. Locate the entry in the All Consults list box for the consult you want to view. You may need to scroll though the list.

Note: To see the full entry line, you can either resize the pane containing the All Consults list or place the mouse pointer over an entry and leave it there to make CPRS display the entire entry line.

3. Click the entry of the consult you want to view.

The consult will then be displayed in the main text box.

Complete a Consult from the Consults tab

To complete a consult from the Consults tab, complete the following steps:

1. Click the Consults tab.
2. Click on **Action | Consult Results | Complete/Update Results**.

Note: If this visit is undefined, you will prompted for encounter type and location, clinician, date, and type of visit, such as Ambulatory, Telephone, or Historical.

3. In the Progress Note Properties dialog, select Progress Note Title (e.g., General, SOAP, Warning, etc.). Additional items will appear on the dialog for titles that require entry of a cosigner or an associated consult.
4. If necessary, change the note date by clicking the button next to the date and entering a new date.
5. If necessary, change the note author by selecting the author from the Author drop-down list.
6. Enter any additional information, such as an associated consult or expected cosigner. Completing these steps will allow the note to be automatically saved.
7. Click **OK**.
8. Create your note by typing text, using templates, and including any test results.

From the Action menu, select either **Sign Note Now** or **Save without Signature**.

Creating a New Consult from the Consults tab

To create a new consult from the Consults tab, complete the following steps:

1. Click the Consults tab.
2. Click the **New Consult** button.
3. If the Provider and Location for Current Activities dialog opens, fill in the Visit Location and other information and click **OK**.
4. Select a service from in the Consult to Service/Specialty window.
5. Fill in a Reason for Consult.
6. Make sure the following have the correct value:
   - Service to perform this procedure
   - Service rendered on
   - Urgency
   - Place of Consultation
   - Attention
   - Provisional Diagnosis
7. Click **Accept Order**.
8. If there are no other procedure orders for this patient, click Quit.

You may sign the consult now or later.

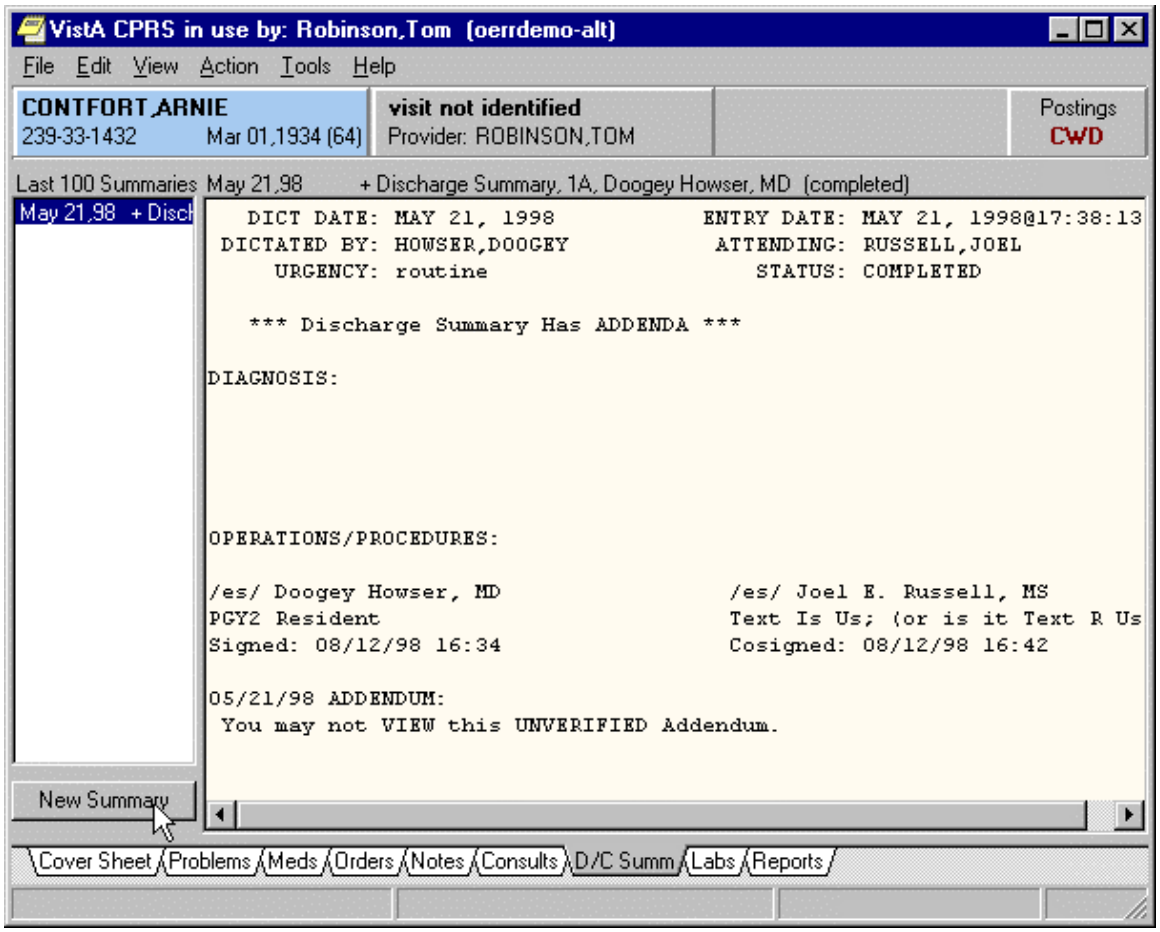
Requesting a New Procedure from the Consults tab

To request a new consult from the Consults tab, complete the following steps:

1. Select the Consults Tab.
2. Click the **New Procedure** button.
3. If the Provider & Location for Current Activities dialog opens, fill in contact information, and click **OK**.
4. Select a procedure.
5. Fill in a Reason for Consult.
6. Make sure the following fields show the correct information:
   - Service to perform this procedure
   - Service rendered on
   - Urgency
   - Place of Consultation
   - Attention
   - Provisional Diagnosis
7. Click **Accept Order**.
8. If there are no other procedure orders for this patient, click **Quit**.
9. You may sign the consult now or later.

Discharge Summary

Discharge Orders are sets of orders to be placed for a patient when checking out of the hospital.



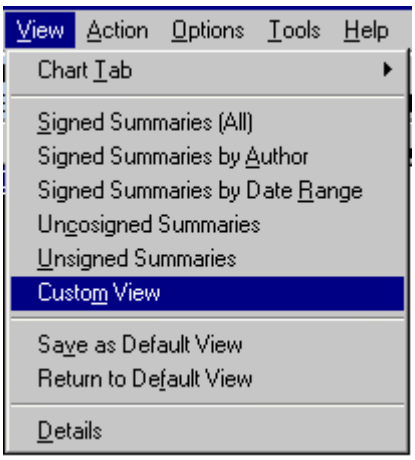
Changing Views on the Discharge Summaries tab

Changing the view of the Discharge Summary tab allows you to focus the list of summaries on one of several criteria. Focusing the list will speed up the selection process.

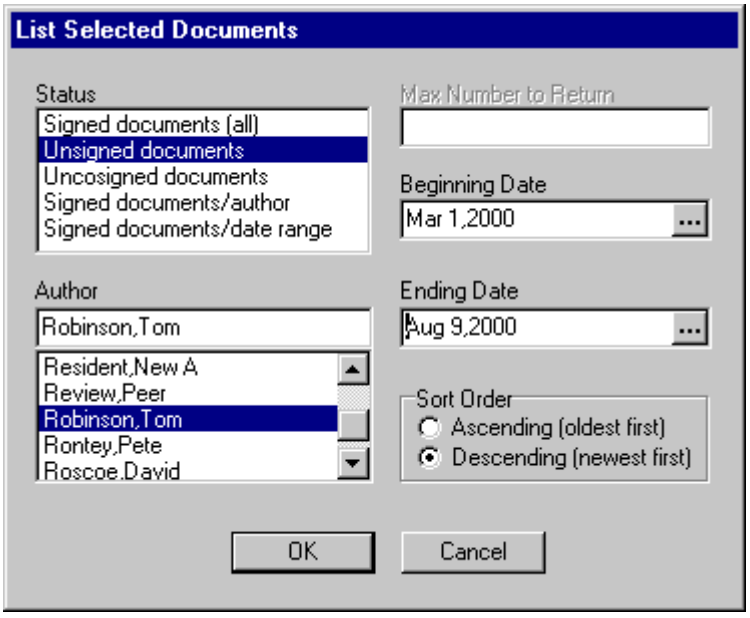
You may change the Discharge Summaries List view to only include the following summaries:

- Signed Summaries (All)
- Signed Summaries by Author
- Signed Summaries by Date Range
- Uncosigned Summaries
- Unsigned Summaries

To change the view, click on View on the menu and select the desired list items.



You may select the Custom View option on the menu to further focus the list of summaries you wish to have displayed. From the List Selected Documents dialog, you may choose to display summaries by any combination of Status, Author, and date range.



To view a discharge summary, use these steps:

1. Click the D/C Summ tab.
2. Click on the summary in the list box.
3. To sort the list, select View and the appropriate choice below:
   - Signed Summaries (All)
   - Signed Summaries by Author
   - Signed Summaries by Date Range
   - Uncosigned Summaries
   - Unsigned Summaries
   - Custom View

Note: To set one of these views as the default, select View | Save as Default.

4. Locate the summary and click on it.

Writing Discharge Summaries

You can enter discharge summaries through CPRS. The document templates and TIU titles that your site can create should make creating these documents much faster and easier.

To write a discharge summary, use these steps:

1. Click the D/C Summ tab.
2. Click New Summary or select **Action | New Discharge Summary**.

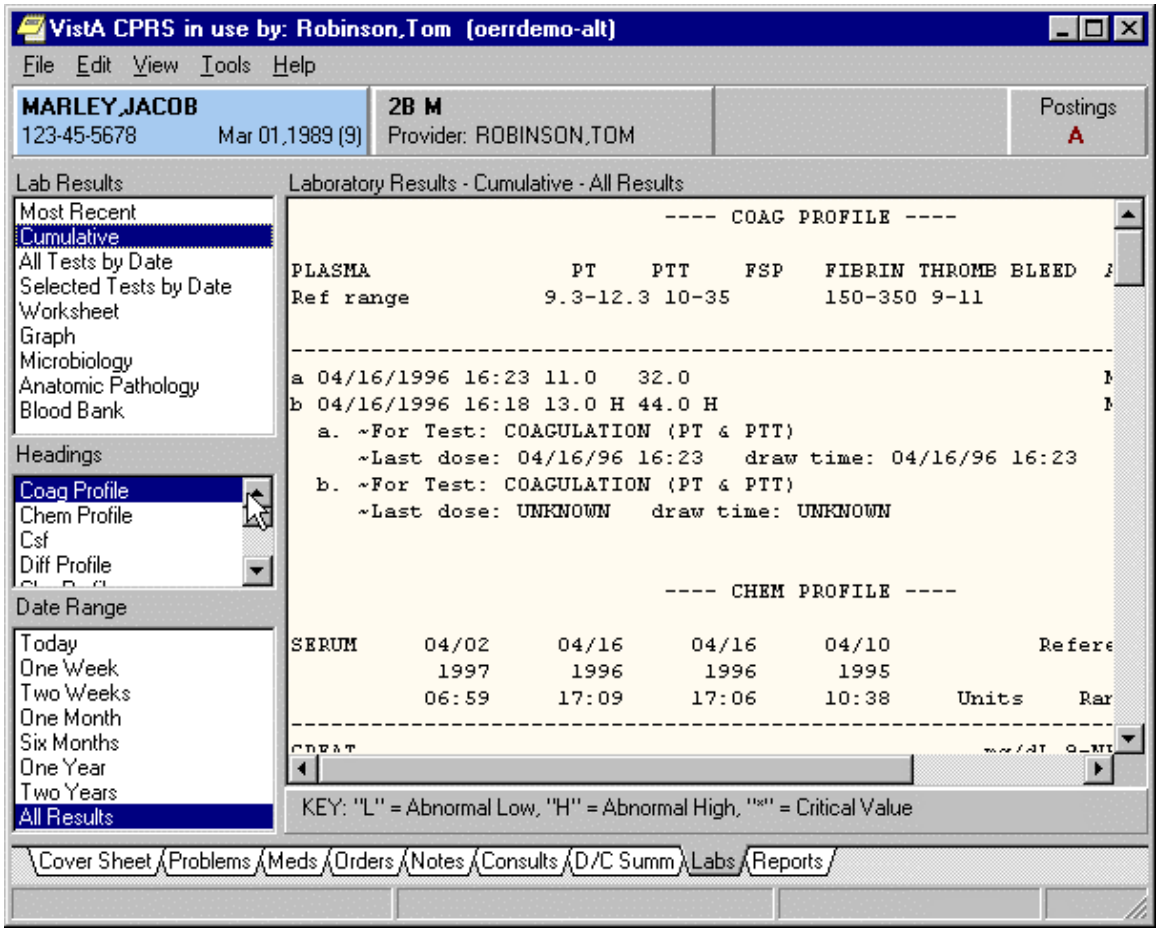
Note: If this visit is undefined, you will prompted for encounter type and location, clinician, date, and type of visit, such as Ambulatory, Telephone, or Historical.

3. In the Discharge Summary Properties dialog, select Discharge Summary Title (e.g., General, SOAP, Warning, etc.). Additional items will appear on the dialog for titles that require entry of a cosigner or an associated consult.
4. If necessary, change the note date by clicking the button next to the date and entering a new date.
5. If necessary, change the note author by selecting the author from the Author drop-down list.
6. Enter the attending physician.
7. Click the admission related to this Discharge Summary.
8. Enter any additional information, such as an expected cosigner. Completing these steps will allow the note to be automatically saved.
9. Click OK.
10. Create the summary content by typing in text, copying and pasting, and/or inserting templates into the document.
11. Click the template drawer if it is not open.
12. Locate the appropriate templates.
13. Double-click the template (You can also drag-and-drop or right-click the template and select Insert Template) and modify as needed.
14. When finished entering text, you may (optional) right-click in the text area and select Check Spelling and Check Grammar.
15. When complete, decide when you will sign the summary and choose the appropriate option:

16 Click Add to Signature List (to place it with other orders or documents you need to sign for this patient). You can also click on Save Without Signature or Sign Discharge Summary Now to sign the summary immediately.

Labs

On the Labs tab, you can view the results of lab tests that were ordered for a selected patient. Ordering of lab test is performed on the Orders tab. The Cover Sheet tab displays results of some of the patient's most recent orders. Some of the lab reports are also found on the Reports tab. The fields on the left side of the Labs tab list available lab results. For some reports, you may need to specify a date range or other criteria. Some reports will prompt for specific tests to be displayed.



Viewing Laboratory Test Results

Through CPRS, you can review lab test results in many formats.

To view lab test results, use these steps:

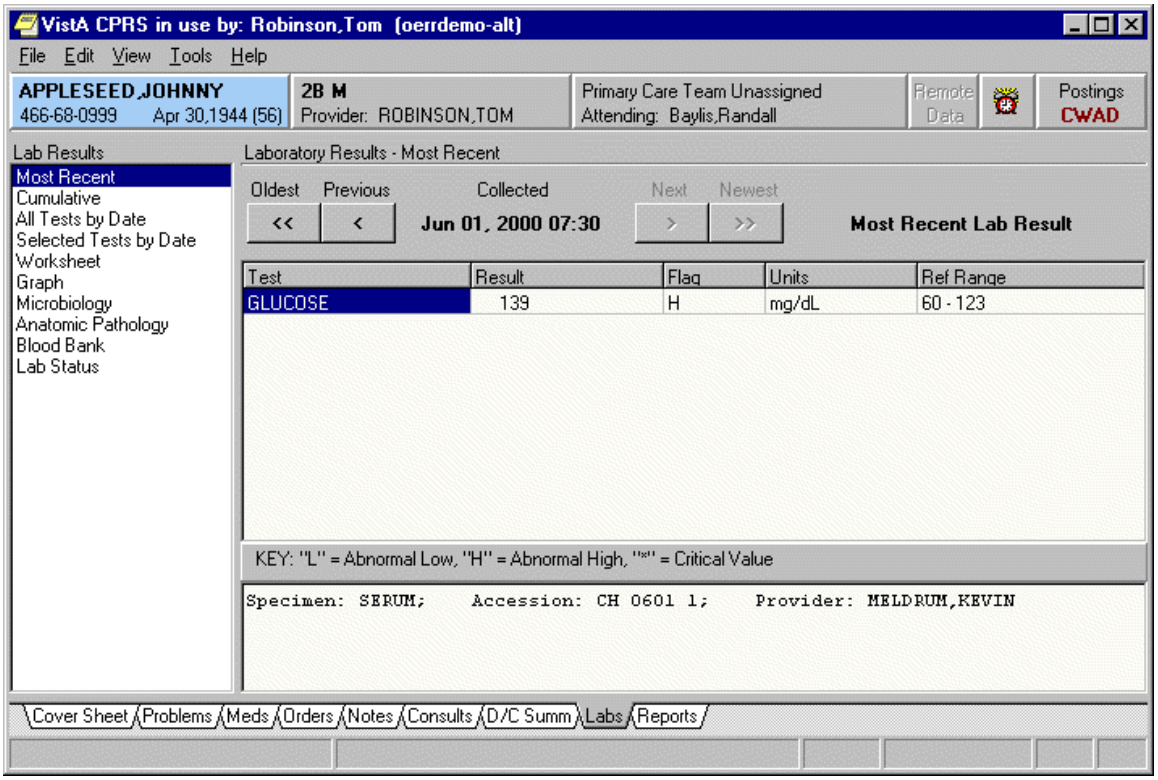
1. Click the Labs tab.
2. In the Lab Results box, click the type of results you want to see. Some of the results will need you to determine which test results you want to see. If the Select Lab Test dialog appears, you need to choose the tests you want to see.

Note: A plus sign (+) by a lab test means it has a schedule.

3. If necessary, select the tests for which you want to see the results.
4. Also, you may need to choose a date range (Today, One Week, Two Weeks, One Month, Six Months, One Year, Two Years, or All Results.)

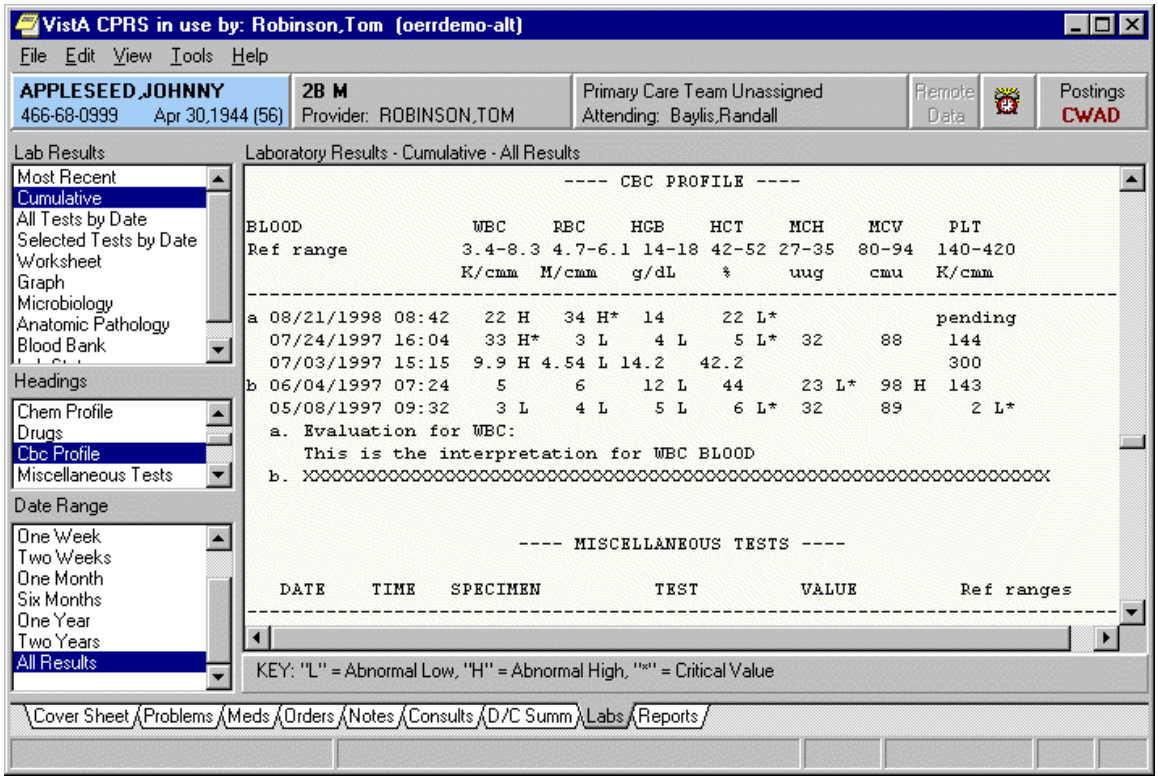
Most Recent

This report allows sequencing back through the most recent results. It displays each set of lab tests in the time they were collected/ it also displays microbiology results and any comments on the collection.



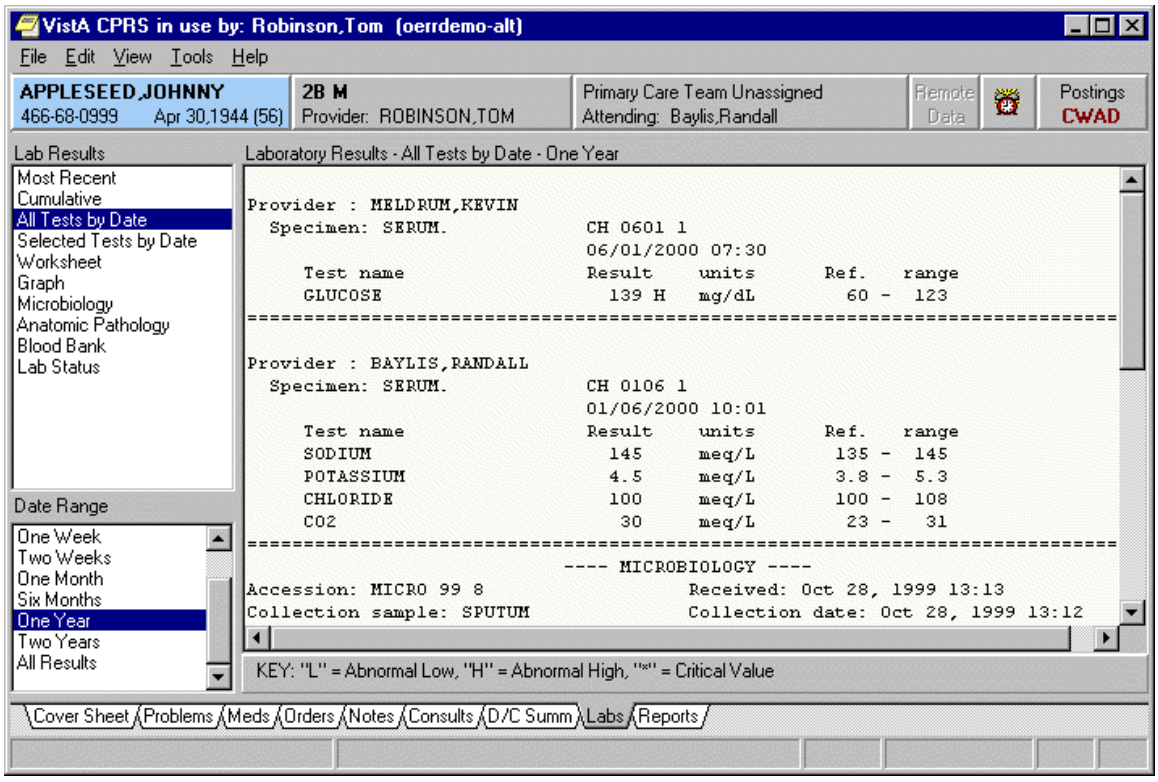
Cumulative

The cumulative report ois he most comprehensive lab report. It displays all of the patient's lab results. When selecting a large data range, this report may take some time before being displayed. The results are organized into sections. You can automatically scroll to that section by selecting it in the Headings list box.



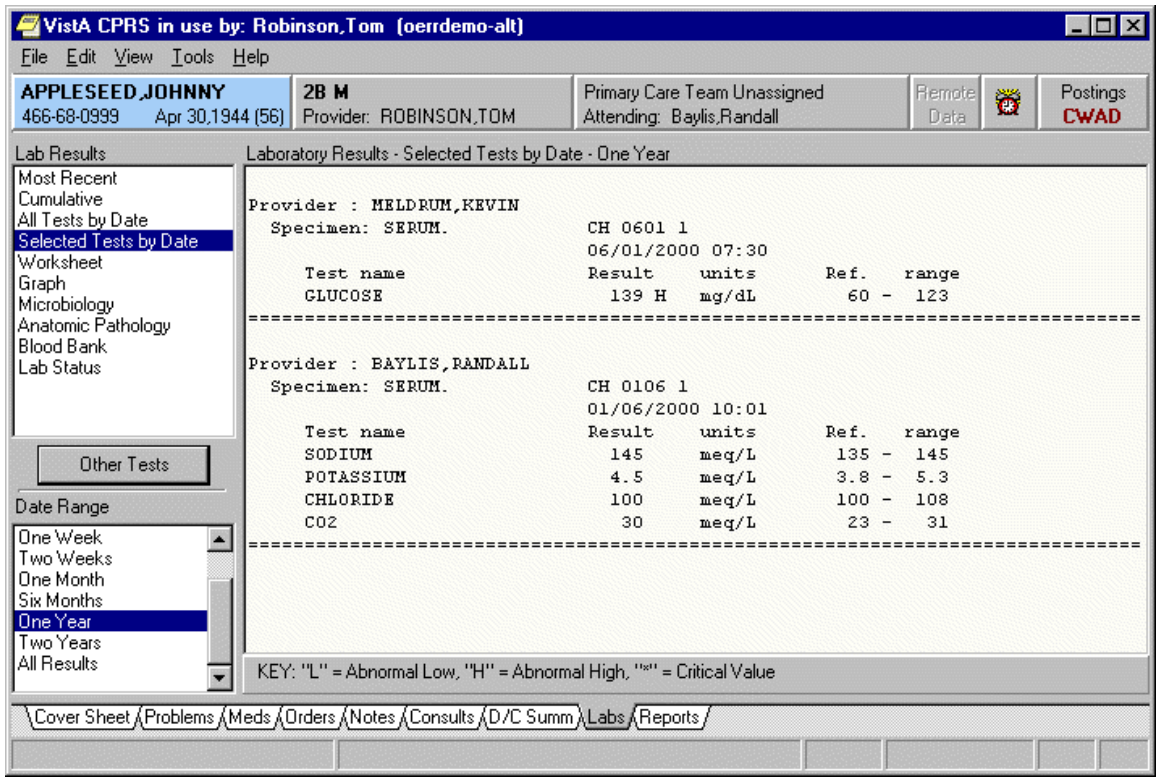
All Tests by Date

This report displays all lab results (except anatomic pathology and blood bank). The data is displayed in the order of the time of collection.



Selected Tests by Date

This report is useful when you only wish to review only specific tests. Microbiology results can also be selected. You will be prompted to select any lab tests. For example, if you select CBC, Chem 7, Lithium, and Liver Profile, only the results for those tests would be displayed.



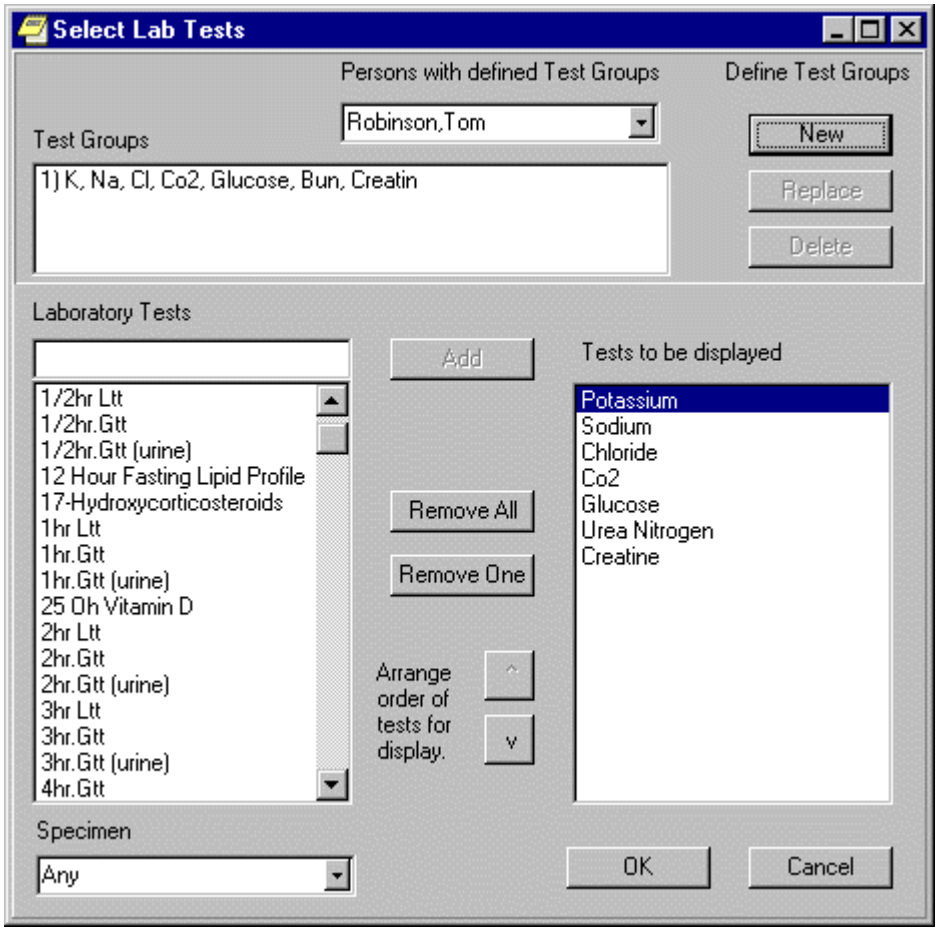
Worksheet

The Worksheet is similar to the Selected Test by Date report. It does not display microbiology results, but it has many features for viewing lab results. It is very useful for displaying particular types of patterns of results.

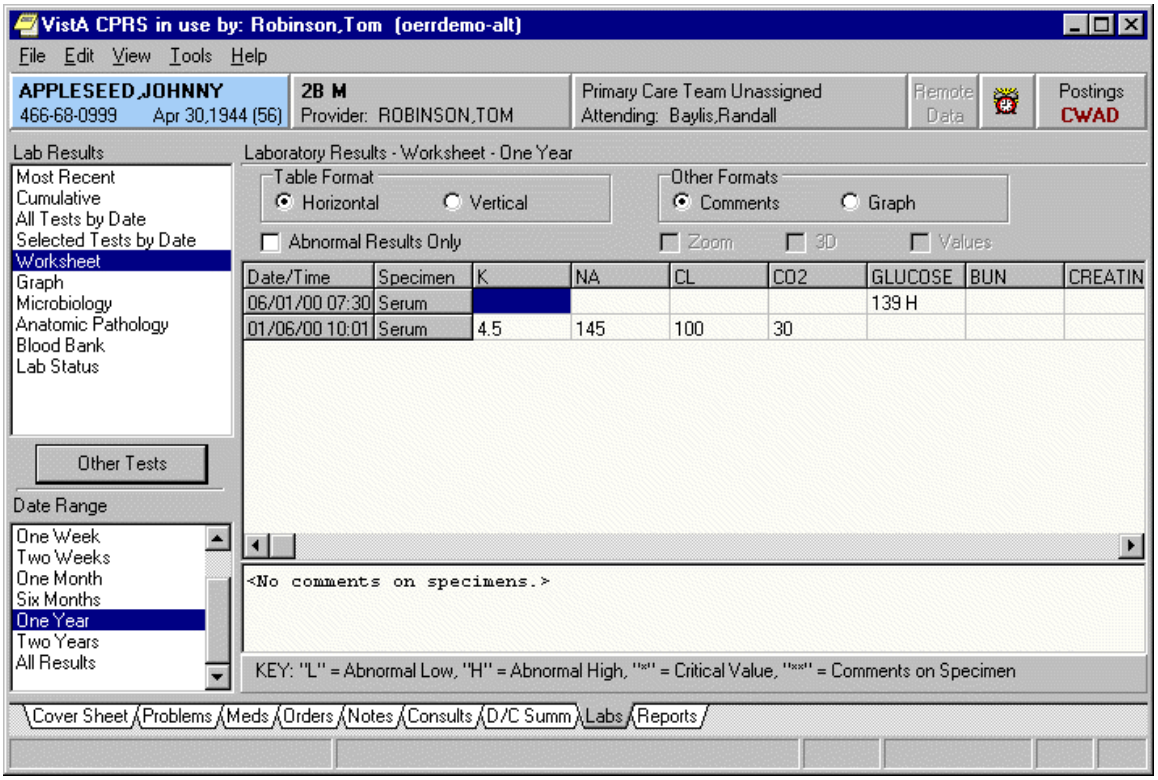
Tests can be selected individually or by test groups. Any number of tests can be displayed. When selecting a panel test, such as CBC, the panel will be expanded to show the individual tests. Tests can be restricted to only display results for asa specific specimen type. For example,: displaying glucose results only on CSF can be made by selecting the specimen CSF and then selecting the test Glucose.

Test groups allow you to combine tests in any manner. For example, a test group could combine CWBC, BUN, Creatinine, and Platelet count. You can save those test groups for later use. You can also select test groups that other users have created. You cannot exchange or delete other's test groups, only your own. Test groups are limited to seven tests, but you may have an unlimited number of test groups. To define your own test groups, select those tests you want and click on the New button. If more than seven tests are selected, the New button will be disabled. If you want to delete a test group, deselect it and click on the Delete button. If you want to replace an existing test group with other tests, select the test group, make any changes to the tests to be displayed and click on the Replace button

Note: These test groups are the same as those you may have already created using the Lab package. The seven-test restriction is a limitation of the Lab package.



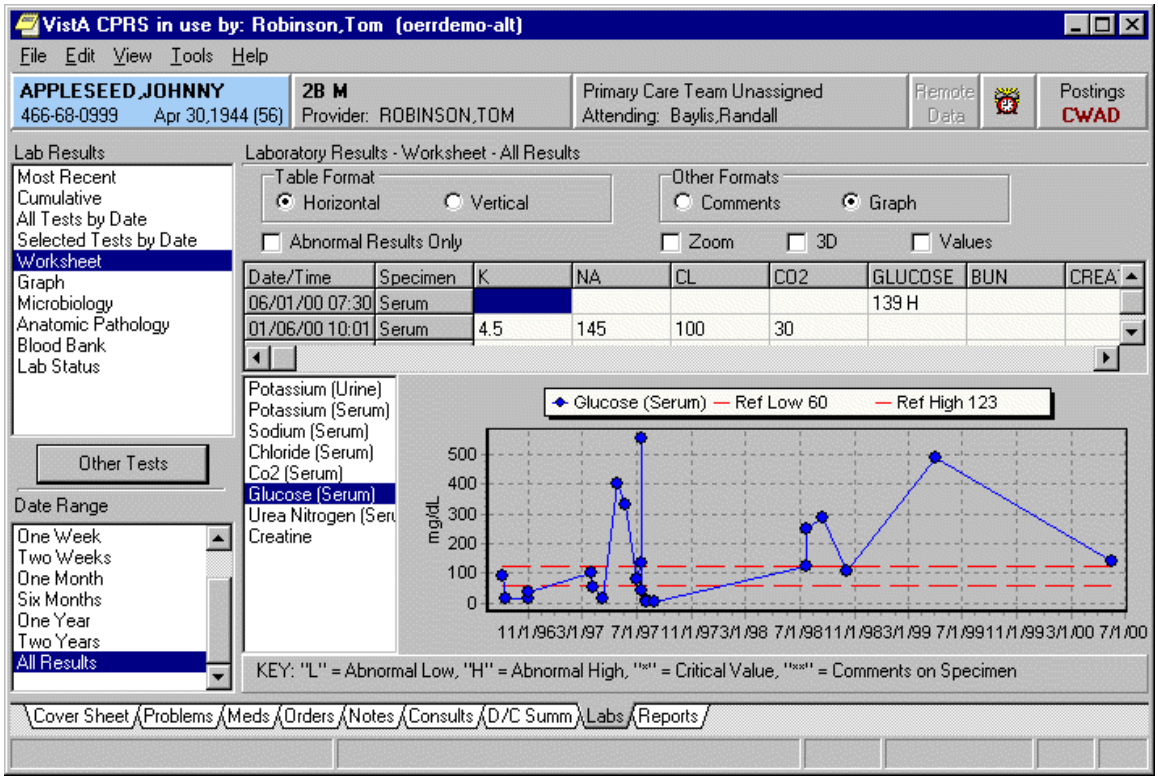
The Worksheet display is a table of results that can be display7ed vertically or horizontally. Since only results are displayed in a table, comments arte foot noted with a ** and shows in the b[panel below the table. You can filter the results to only show abnormal values. This will quickly show tests that have results beyond their reference values.



You can toggle between view comments and graph view. The graph format displays each test separately. By selecting each test, you see the trend in values for each time range. You may also use features to Zoom, apply 3D, and display values on graph. Zooming is allowed when checking the Zoom check box. You may then click on the graph and drag a rectangular area to zoom in on. To undo the zoom feature, you can uncheck the Zoom check box or drag a rectangular area in the upper left corner of the graph and then release the mouse button.

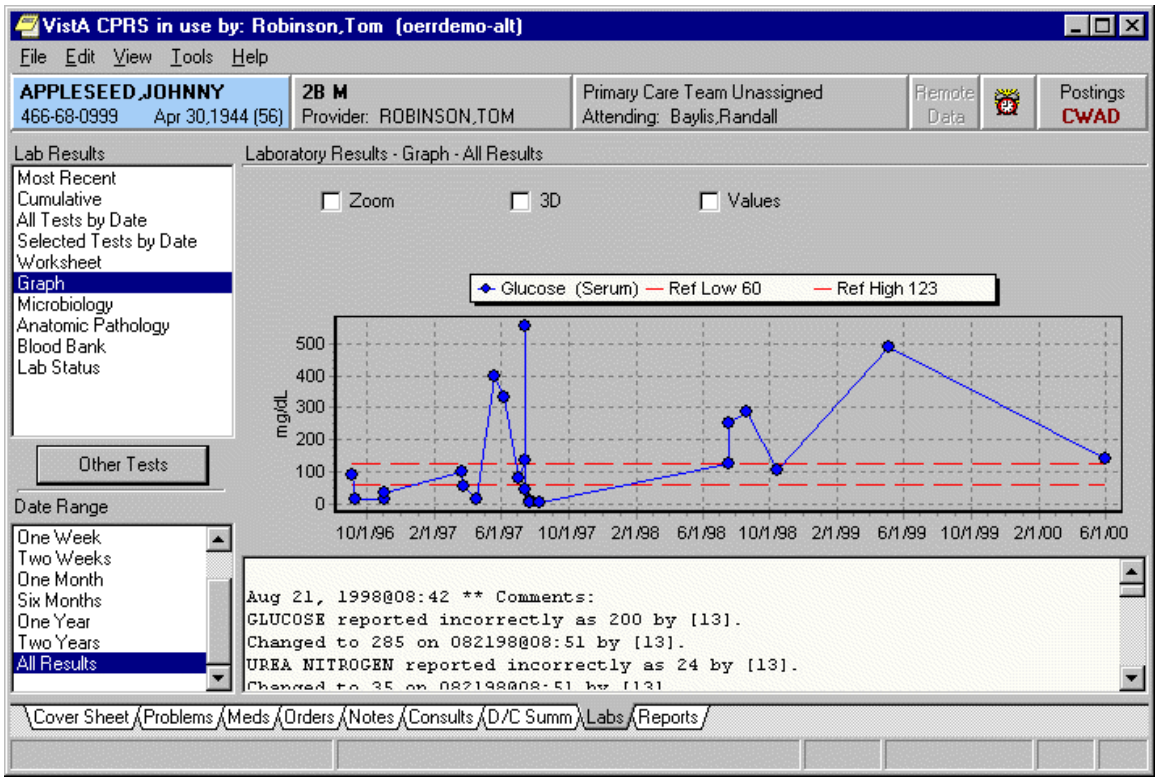
Note: Zoom will retain the selected date range when you change to other tests or test groups. This is helpful when you are looking for trends within a given time period.

A right-click on the graph will bring up a pop-up menu with other actions. You can display details of the lab test by right-clicking a point on the graph and then selecting **Details**. This will display all test values for this collection time. Right-clicking on the graph will display all values for the selected test.



Graph

This report displays a single test in a graph. Comments are included. Zoom, 3D, and Values function the same as in the Worksheet graph. The right-click actions are also the same.

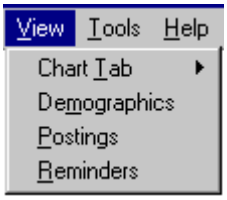


Microbiology, Anatomic Pathology, Blood Bank, Lab Status

These reports display only the results from these portions of the laboratory. The Lab Status report displays the status on current orders.

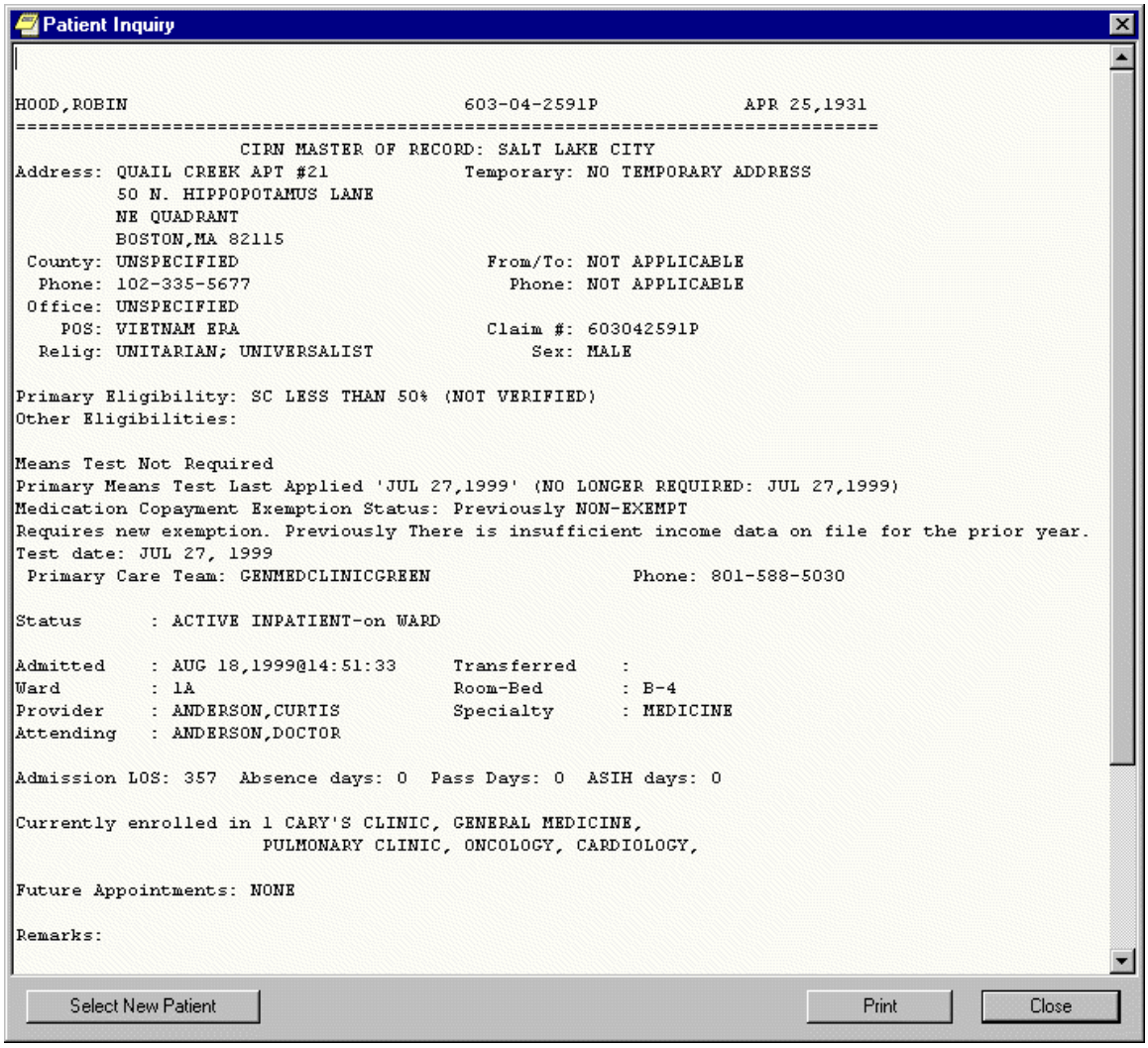
Changing Views on the Labs tab

The View menu on the Labs tab is different from most of the other tabs in that the menu options do not sort or focus the listed items. The menu items are a way to open different windows and displays with information the clinician may need to see in conjunction with the lab results.



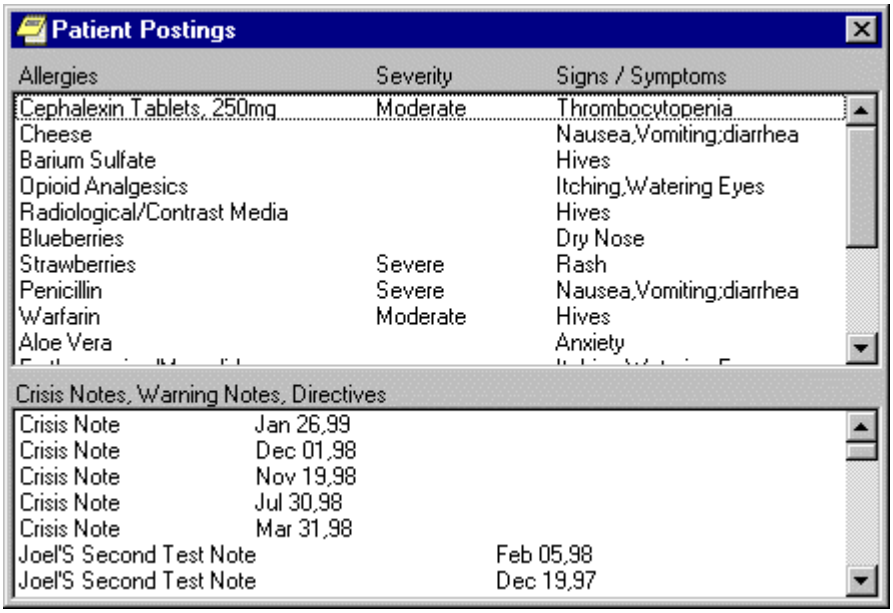
Demographics

From the Labs tab, click on **View | Demographics** to display the Patient Inquiry screen of the currently selected patient.



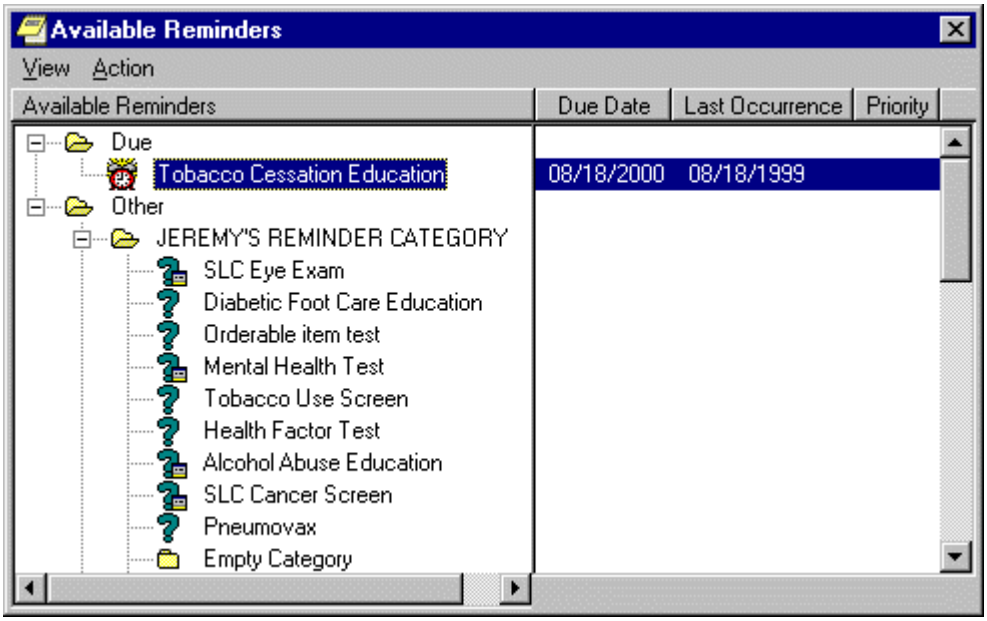
Postings

From the Labs tab, click on **View | Postings** to display the Patient Postings screen of the currently selected patient. The Patient Postings windows displays information about the patient's allergies, and any Crisis Notes, Warning Notes, and Directives that may apply to the patient.



Reminders

From the Labs tab, click on **View | Reminders** to display the Available Reminders dialog for the currently selected patient. The Available Reminders dialog allows you to review all reminders including the ones that apply to the currently selected patient.

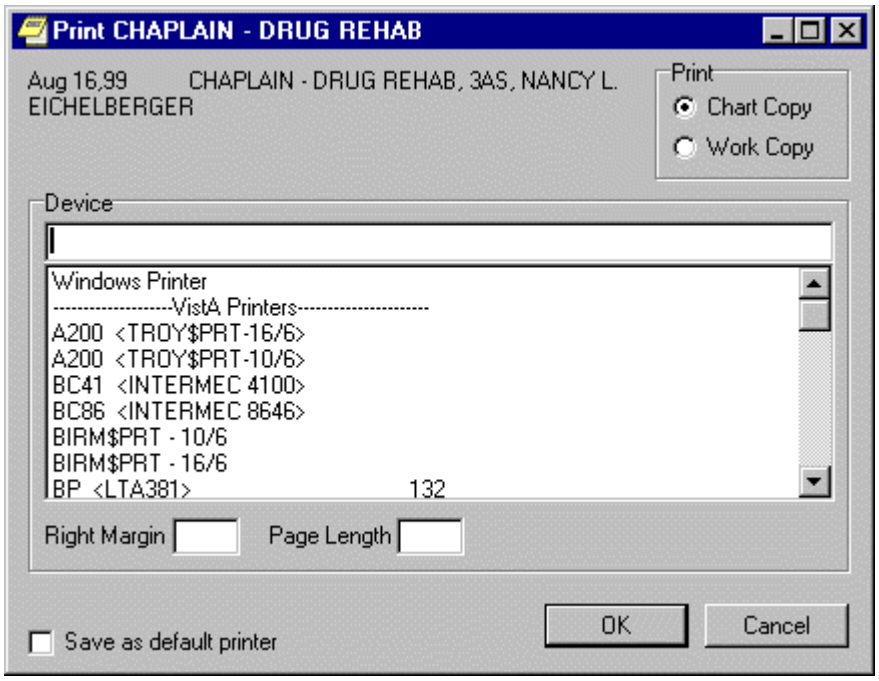


Reports

Currently, you can print reports from the Problems, Consults, Labs, Notes, Discharge Summary, and Reports tabs to any VISTA printer defined on the server or to a Windows printer.

You can also now print graphics on a Windows printer from the Labs tab and the Vitals screen. You can use **File | Print Setup...** to set up a preferred printer for the current session and save it as the default for the user.

The dialog box shown below comes up when you select **File | Print** from the Notes tab. A similar dialog, without the Chart copy / Work copy option appears for items on other tabs. Many report boxes now have Print button on them to make it easier for you to print the information you need. With most reports you can select a date range and sub-topics to customize your reports.



Normally, you do not need to enter a right margin or page length value. These values are measured in characters and normally are already defined by the device.

You will also still have the options to print your regular tasked jobs.

Reviewing a Health Summary

If you select Health Summary, choose the "Health Summary Type."

Note: Only health summaries that do no additional prompting may be selected (i.e., all time and occurrence limits must be already defined). Because the GUI cannot drop into a character-based scrolling dialog, ad hoc health summaries are not allowed.

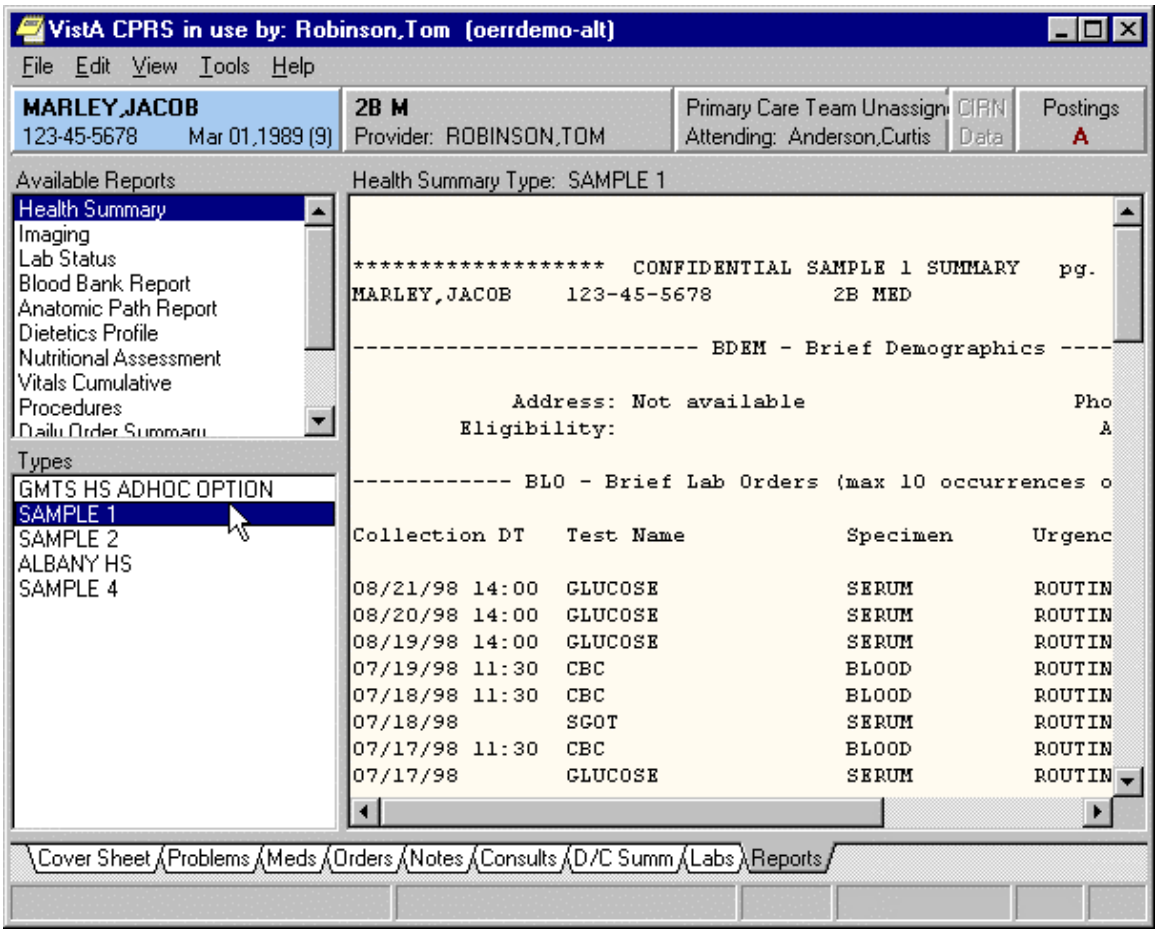
To display a Health Summary, follow these steps:

1. Select a patient after you enter the CPRS system.
2. Select the Reports tab.

3. Under the Available Reports box on the left side of the screen, click Health Summary.

4. Select a type from the Types box. The Health Summary for this patient is displayed.

5. Use the scroll bar on the right to scroll through the different sections of the Health Summary.



Appendix A – Personal Preferences

You can change many of the parameters that control the way CPRS works for you. The Personal Preferences Menu on your Clinician Menu contains sub-menus that may allow you to change which notifications and order checking messages you get, manage team and personal lists, assign your default patient selection settings, and modify your default tab preferences.

Personal Preferences Menu

Option or Menu	Description
GUI Cover Sheet Display Parameters	This option allows you to modify the default number of days to display inpatient and outpatient labs, the start and stop search date for appointments and visits, and the clinical reminders and reports to be displayed on the cover sheet.
GUI Parameters - General	This option allows you to modify which chart tab will be displayed on startup, whether to use the last selected tab, how often to save notes (in seconds) and whether or not to verify the default title when creating a new note.
Team/Patient List Management	This option allows you to make changes to your Personal Patient List, to display patients linked to you via teams, to display teams on which you are a member. It also allows you to add or remove yourself from auto-linked teams.
Notification Management Menu	This menu contains an option that allows you to review the notifications you should be currently receiving. You may also have an option for adding or removing notifications to those you are scheduled to receive (whether you have this depends on local site set-up). Use this option to turn notifications on or off. You may also be able to remove all of your existing notifications via a purge option.
Order Checking Management Menu	This menu contains one or two options (depending on local set-up) which allow you to check which order checks you get and possibly to enable or disable specific order checks.
Patient Selection Preference Mgmt	This menu allows you to set default parameters for patient lists.
Tab Default Chart Preferences	This option allows setting a number of parameter defaults for each of the tabs. The 10 selections include parameters such as beginning date, ending date, service, and status.

To access the Personal Preferences Menu:

```
   OE     CPRS Clinician Menu
   RR     Results Reporting Menu
   AD     Add New Orders
   RO     Act On Existing Orders
   PP     Personal Preferences ...

Select Clinician Menu Option: PP  Personal Preferences

   CS     GUI Cover Sheet Display Parameters
   GP     GUI Parameters - General
   LI     Team/Patient List Mgmt ...
   NO     Notification Mgmt Menu ...
   OC     Order Checking Mgmt Menu ...
   PS     Patient Selection Preference Mgmt ...
   TD     Tab Default Chart Preferences
Select Personal Preferences Option:
```

GUI Cover Sheet Display Parameters

This option allows you to set display parameters defaults for the GUI Cover Sheet. Each parameter comes with a default value, which can be overridden. The example shows the "factory" defaults and some options for customizing them for a user.

Example

```
Select Personal Preferences Option: CS  GUI Cover Sheet Display
Parameters

GUI Cover Sheet - User for User: GREEN,JOANN
------------------------------------------------------------------------
Inpatient Lab Number of Days to Display           60
Outpatient Lab Number of Days to Display          120
Appt Search Start Date                            T-30
Appt Search Stop Date                             T+60
Visit Search Start Date                           T-30
Visit Search Stop Date                            T+60
Clincal Reminders for Search  10                  VA-INFLUENZA VACCINE
------------------------------------------------------------------------
Inpatient Lab Number of Days to Display: 60//
Outpatient Lab Number of Days to Display: 120//
Appt Search Start Date: T-30//
Appt Search Stop Date: T+60//
Visit Search Start Date: T-30//
Visit Search Stop Date: T+60//

For Clincal Reminders for Search -
Select Display Sequence: ?

     Display Sequence              Value
     ----------------              -----
     10                            VA-INFLUENZA VACCINE

Select Display Sequence: 12
Are you adding 12 as a new Display Sequence? Yes// <Enter>  YES

Display Sequence: 12// <Enter>   12
Clinical Reminder: Tetanus Diptheria (TD-Adult)  VA-*TETANUS DIPTHERIA
IMMUNIZATION

For Clincal Reminders for Search -
Select Display Sequence: <Enter>
```

GUI Parameters – General

This option allows you to set a number of general display parameters defaults for the GUI version of CPRS. Each parameter comes with a default value, which can be overridden. The *Interval for Autosave of Notes* is expressed in seconds.

Example

```
Select Personal Preferences Option: GP  GUI Parameters - General

General GUI Parameters for User: GREEN,JOANN
------------------------------------------------------------------------------
Initial Tab when CPRS Starts                        Cover
Use Last Selected Tab on Patient Change             NO
Interval for Autosave of Notes                      60
Verify Note Title                                   NO
------------------------------------------------------------------------------
Initial Chart Tab: Cover//
Use Last Selected Tab: NO//
Auto-Save Interval: 60//
Verify Default Title: NO//
```

Team/Patient List Management

The menu choices that report or display information will allow access to Team Lists of all kinds. For those menu choices that provide for creation or editing of a list, however, you will be restricted to your "personal" patient list. You may create more than one personal list and assign a different such list from time to time. From these menus, you cannot create or modify lists that belong to others or that are not your own personal lists.

The following options may be available on your Personal Preference Menu, depending on how your local coordinators have set up your menus. The team lists also help determine who receives notifications for patients defined on the lists.

Option	Description
Personal Patient List Menu…	Options on this menu allow clinicians to create patient lists by ward, clinic, or by patient to use for displaying results or creating reports. You can build lists, delete lists, merge lists, add or remove patients from lists, or inquire to a file of patient lists.
Display Patients Linked to Me Via Team	This option displays patients linked to the current user via teams from the OE/RR LIST file [#100.21].
Display My Teams	This option displays teams linked to the current user.
Add/Remove Myself from Autolinked Teams	This option allows you to add yourself to teams to which you were not automatically linked or to remove yourself from teams to which you were automatically linked. This feature only works when subscription to the Team Lists has been allowed.

Personal Patient List Menu

Clinical Coordinators can help set up team lists for groups of clinicians and related hospital personnel. Clinicians can create patient lists by ward, clinic, or by patient to use for displaying results or creating reports. You can build lists, delete lists, merge lists, add or delete patients from lists, or inquire to a file of patient lists.

If you have a list defined and loaded (as determined in the Personal Preferences options), the list will be available and can be used as a basis for patient selection every time you select the CPRS Clinician Menu. You then select a patient from the list. This list can also be used for printing reports.

Option	Description
Build Patient List Menu…	Options on this menu allow you to create patient lists by patient, ward, or clinic. These lists can then be used to display results or to print reports, or can be merged with other lists.
Merge Existing Lists	This option lets you merge the patients from one or several lists together to create a bigger or more comprehensive list.
Examine/Print Existing Lists	This option allows you to examine or print an existing patient list.
Delete Existing Lists	When you no longer need a patient list that you have built, you can use this option to delete the list.
Load Primary Patient List	This option loads into the current session the user's primary patient list.

Build Patient List Menu

The following options may be available on your Build Patient List Menu, depending on how your local coordinators have set up your menus.

Option	Description
Patient (Add to List)	This option allows you to add a patient to your Patient List.
Ward (Add to List)	This option allows you to add a ward to your Patient List.
Clinic (Add to List)	This option allows you to add a clinic to your Patient List.
Provider (Add to List)	This option allows you to add a provider to your Patient List.
Specialty (Add to List)	This option allows you to add a specialty to your Patient List.
Existing List (Add to List)	This option allows you to add an existing list to your Patient List.
Clear Current Patient List	This option removes all patients from your current Patient List.
Show Current Patient List	This option displays all patients on your current Patient List.
Remove Patient from Patient List	This option allows you to remove selected patients from your current Patient List.

Example: Build Patient List Menu

```
Select Personal Patient List Menu Option: AD  Build Patient List Menu
   ON     Patient        (Add to list)
   WA     Ward           (Add to list)
   CL     Clinic         (Add to list)
   PV     Provider       (Add to list)
   TS     Specialty      (Add to list)
   AL     Existing Lists (Add to list)
   CR     Clear Current Patient List
   LI     Show Current Patient List
   DE     Remove Patient(s) from Patient List

Select Build Patient List Menu Option: PV  Provider       (Add to list)
No existing list found, continuing with an EMPTY list.

Select PROVIDER: GREEN,JOANN       jg

     Select one of the following:
          P         PRIMARY CARE PHYSICIAN
          A         ATTENDING PHYSICIAN
          B         BOTH

Select: BOTH// <Enter>
Working...
Show your current PATIENT list? No// Y  (Yes)

                       CURRENT PATIENT LIST

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------------------------------------------------------------------------------

   1 APPLESEED, J
   2 BUD,ROSE
   3 EASY,OVER
   4 HOOD,ROBIN
   5 NIVEK,ALPHA
   6 READING,TRISHA
   7 TEAGUE,TEST
   8 ZORRO,MIGUEL

Press RETURN to continue                                  "^" to Quit

Do you want to remove patients from this list? No// <Enter>   (No)

Store list for future reference? Yes// <Enter>   (Yes)
Enter a name for this list: GREENLIST
  Are you adding 'GREENLIST' as a new OE/RR LIST? No// Y  (Yes)

List has been stored.
```

Display Patients Linked to Me via Teams

This option displays patients who are linked to teams with which you are currently associated.

Example

```
   CS     GUI Cover Sheet Display Parameters
   NO     Notification Mgmt Menu ...
   OC     Order Checking Mgmt Menu ...
   PL     Personal Patient List Menu ...
   PS     Patient Selection Preference Mgmt ...
   PT     Display Patients Linked to Me via Teams
   TM     Display My Teams

Select Personal Preferences Option: pt  Display Patients Linked to Me via
Teams


    GREEN,JOANN IS LINKED TO THE FOLLOWING PATIENTS VIA TEAMS:

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------------------------------------------------------------------------------

   1 APPLESEED,JOHNNY       17 SCHWARTZ,ARNOLD
   2 BUD,ROSE               18 SIMPSON,HOMER
   3 DOE,WILLIAM C.         19 STONE,JERRY
   4 EASY,OVER              20 TEAGUE,TEST
   5 FEET,SMELL E.          21 TRAT,JACK
   6 HOLMES,SHERLOCK        22 WINCHESTER,CHARLE
   7 HOOD,ROBIN             23 ZORRO,MIGUEL
   8 KIMINATOR,THE
   9 LAY,FRITO
  10 MUFFET,LITTELLA M
  11 NEW,PATIENT
  12 NIVEK,ALPHA
  13 NIVEK,SIGMA
  14 RAMBO,JOHNNY
  15 READING,TRISHA
  16 REGISTER,NEW PATI

Press RETURN to continue                                      "^" to Quit
```

Display My Teams

This option displays teams with which you are currently associated.

Example

```
Select Clinician Menu Option: PP  Personal Preferences

   CS     GUI Cover Sheet Display Parameters
   NO     Notification Mgmt Menu ...
   OC     Order Checking Mgmt Menu ...
   PL     Personal Patient List Menu ...
   PS     Patient Selection Preference Mgmt ...
   PT     Display Patients Linked to Me via Teams
   TM     Display My Teams


You have PENDING ALERTS
          Enter  "VA   VIEW ALERTS     to review alerts

Select Personal Preferences Option: TM  Display My Teams



              GREEN,JOANN IS ON THE FOLLOWING TEAMS:

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------------------------------------------------------------------------------

   1 AUTOLINKED TEAM--
   2 GREENLIST
   3 House of Murph
   4 teamqa




Press RETURN to continue                                        "^" to Quit
```

Notification Management Menu Options

The following options may be available on your Personal Preference Menu, depending on how your local coordinators have set up your menus.

Option	Description
Enable/Disable My Notifications	If you have this option, you can indicate that a notification should not be processed for you.
Erase All of My Notifications	Use this option to erase all of your own notifications.
Set Notification Display Sort Method (GUI)	Method for sorting notifications when displayed in the GUI, including by Patient, Type (Notification name), and Urgency. Within these sort methods notifications are presented in reverse chronological order.
Send me a MailMan bulletin for Flagged Orders	Enter Yes to send a bulletin to the order's Current Provider (usually the Ordering Provider) when an order is flagged for clarification. This parameter has no effect on the Flagged Orders notification which is also triggered when an order is flagged for clarification.
Show Me the Notifications I Can Receive	This option displays if and why you are a recipient for each notification.
Set Surrogate to Receive My Notifications	Sets up a surrogate to receive all notifications (OE/RR alerts) for you.

Example: Show Me the Notifications I Can Receive

```
Select Notification Mgmt Menu Option: 5  Show Me the Notifications I Can
Receive
Would you like help understanding the list of notifications? No//  (No)
This will take a moment or two, please stand by.....................
DEVICE: HOME//   ALPHA

             Notification List for GREEN,JOANN              Page:   1

Notification                      ON/OFF For This User and Why
-------------------------------  ------------------------------------
ABNORMAL IMAGING RESULTS          ON   System value is Mandatory
ABNORMAL LAB RESULT (INFO)        OFF  OERR value is Disabled
ABNORMAL LAB RESULTS (ACTION)     ON   No Disabled values found
ADMISSION                         ON   No Disabled values found
CONSULT/REQUEST CANCEL/HOLD       ON   No Disabled values found
CONSULT/REQUEST RESOLUTION        ON   No Disabled values found
CRITICAL LAB RESULT (INFO)        ON   User value is Enabled
CRITICAL LAB RESULTS (ACTION)     OFF  OERR value is Disabled
DECEASED PATIENT                  ON   No Disabled values found
DISCHARGE                         ON   No Disabled values found
DNR EXPIRING                      OFF  OERR value is Disabled
ERROR MESSAGE                     ON   No Disabled values found
FLAGGED ORDERS                    ON   No Disabled values found
FOOD/DRUG INTERACTION             ON   No Disabled values found
FREE TEXT                         ON   No Disabled values found
IMAGING PATIENT EXAMINED          ON   No Disabled values found
IMAGING REQUEST CANCEL/HELD       ON   No Disabled values found
IMAGING RESULTS                   ON   No Disabled values found
IMAGING RESULTS AMENDED           ON   No Disabled values found
LAB ORDER CANCELED                ON   Division value is Mandatory
LAB RESULTS                       OFF  System value is Disabled
MEDICATIONS EXPIRING              OFF  OERR value is Disabled
NEW ORDER                         ON   No Disabled values found
NEW SERVICE CONSULT/REQUEST       ON   No Disabled values found
NPO DIET MORE THAN 72 HRS         OFF  OERR value is Disabled
ORDER CHECK                       OFF  OERR value is Disabled
ORDER REQUIRES CHART SIGNATURE    OFF  Division value is Disabled
ORDER REQUIRES CO-SIGNATURE       ON   No Disabled values found
ORDER REQUIRES ELEC SIGNATURE     ON   User value is Enabled
ORDERER-FLAGGED RESULTS           OFF  OERR value is Disabled
SERVICE ORDER REQ CHART SIGN      ON   No Disabled values found
SITE-FLAGGED ORDER                OFF  OERR value is Disabled
SITE-FLAGGED RESULTS              OFF  OERR value is Disabled
STAT IMAGING REQUEST              OFF  Division value is Disabled
STAT ORDER                        OFF  OERR value is Disabled
STAT RESULTS                      ON   User value is Enabled
TRANSFER FROM PSYCHIATRY          OFF  System value is Disabled
UNSCHEDULED VISIT                 ON   No Disabled values found
UNVERIFIED MEDICATION ORDER       OFF  Division value is Disabled
URGENT IMAGING REQUEST            OFF  OERR value is Disabled

           - End of Report -
```

Explanations of ON/OFF For This User and Why

There can be several reasons why a notification is enabled (turned "on") or disabled (turned "off"). The table gives an explanation of each reason that may be applied.

Reason	Explanation
Division/System value is Mandatory	Either the site or the CPRS package determined that a notification is mandatory for either a division or a hospital.
OERR value is Mandatory	The notification is exported as mandatory.
OERR value is Disabled	The site disabled the mandatory status of an exported notification.
No Disabled values found	No one (a manager, coordinator, or user) has disabled this notification.
User value is Disabled	A manager, coordinator, or user disabled this notification for this user.

Disabling a Notification Example

The process for disabling a notification seems counter-intuitive. When the program asks if you want to add a new Notification, logically you'd want to say "No," but the program is really asking if you want to add a new notification to a temporary list for consideration about enabling or disabling. The program is using a generic FileMan call—we hope that in the near future a more user-friendly utility will be written for this option.

```
Select Personal Preferences Option: NO  NOTIFICATIONS MGMT MENU
Select Notification Mgmt Menu Option: 1  Enable/Disable Notifications

                        Enable/Disable My Notifications
--------------------------------------------------------------------------------

---------------------- Setting   for User: GREEN,JOANN ------------------

Select Notification: ?

     Notification                  Value
     ------------                  -----
     LAB RESULTS                   Disabled
     ORDER REQUIRES ELEC SIGNATURE Mandatory
     CRITICAL LAB RESULT (INFO)    Mandatory
     STAT RESULTS                  Mandatory
     FREE TEXT                     Disabled

 Answer with OE/RR NOTIFICATIONS NUMBER, or NAME, or PACKAGE ID, or
     MESSAGE TEXT, or RECIPIENT USERS
 Do you want the entire 41-Entry OE/RR NOTIFICATIONS List? N  (NO)

Select Notification: ADMISSION
Are you adding ADMISSION as a new Notification? Yes// <Enter>   YES

Notification: ADMISSION// <Enter>   ADMISSION   ADMISSION

Value: Disabled
Select Notification: <Enter>
```

Order Checking Management Menu

The two options on this menu allow you to enable or disable various order checks and it can show you the order check you can receive.

Option	Description
Enable/Disable an Order Check for Yourself	A list of available order checks is displayed when you enter a question mark. You can then select order checks to enable or disable.
Show Me the Order Checks I Can Receive	This option processes each order check to determine if and why you receive an order check message during the ordering process.

Example: Enable/Disable an Order Check for Yourself

```
Select Clinician Menu Option: PP  Personal Preferences
   CS     GUI Cover Sheet Display Parameters
   NO     Notification Mgmt Menu ...
   OC     Order Checking Mgmt Menu ...
   PL     Personal Patient List Menu ...
   PS     Patient Selection Preference Mgmt ...
   PT     Display Patients Linked to Me via Teams
   TM     Display My Teams

Select Personal Preferences Option: Order Checking Mgmt Menu
Select Order Checking Management Option: 1  Enable/Disable an Order Check for
Yourself
--------------------------------------------------------------------------------
------------- Setting PROCESSING FLAG for User: GRIN,JON ---------
Select Order Check: ?
 Answer with ORDER CHECKS NAME
 Do you want the entire 18-Entry ORDER CHECKS List? y  (Yes)
Choose from:
   ALLERGY-CONTRAST MEDIA INTERAC
   ALLERGY-DRUG INTERACTION
   AMINOGLYCOSIDE ORDERED
   BIOCHEM ABNORMALITY FOR CONTRA
   CLOZAPINE APPROPRIATENESS
   CT & MRI PHYSICAL LIMITATIONS
   DRUG-DRUG INTERACTION
   DUPLICATE DRUG CLASS ORDER
   DUPLICATE DRUG ORDER
   DUPLICATE ORDER
   ERROR MESSAGE
   ESTIMATED CREATININE CLEARANCE
   GLUCOPHAGE-CONTRAST MEDIA
   LAB ORDER FREQ RESTRICTIONS
   MISSING LAB TESTS FOR ANGIOGRA
   ORDER CHECKING NOT AVAILABLE
   POLYPHARMACY
   RECENT BARIUM STUDY
   RECENT ORAL CHOLECYSTOGRAM
   RENAL FUNCTIONS OVER AGE 65
Select Order Check: DUPLICATE DRUG ORDER
Are you adding DUPLICATE DRUG ORDER as a new Order Check? Yes//<Enter>YES
Order Check: DUPLICATE DRUG ORDER//  <Enter>    DUPLICATE DRUG ORDER
  Value: Enabled// <Enter>   Enabled
    Order Check                    Value
     -----------                    -----
     DUPLICATE DRUG ORDER           Enabled
```

You're not really adding a new Order Check, but a new Order Check Value:

Enabled.

Patient Selection Preference Menu

The first of these menu options is where you assign your default Patient Selection List Source. This is the source of the patients displayed when you enter CPRS.

Menu options two through five allow you to pre-assign default settings for the various sources you use with menu option one.

Menu options seven through 15 allow you to pre-assign default settings for clinics, for use when you select clinics as your source using menu option one.

Menu option 16 allows you to assign a default sort order for the source you assign with menu option one. Note that certain sort defaults will work only with certain kinds of sources. If you select a sort that does not apply, a "built-in default" will be used instead (usually alphabetic).

Menu option 17 simply displays your current source setting (whatever you may have assigned with menu option one.

Option	Description
1. Set My Preferred List Source	This option lets you specify the default preference for patient list source when starting CPRS – based on the following default types that you can pre-define.
2. Set My Preferred Ward	This option lets you specify a default Ward that can be used as your patient selection list.
3. Set My Preferred Provider	This option let you specify a default provider who's patients can be used as a basis for your patient selection list.
4. Set My Preferred Treating Specialty	This option lets you specify a default Treating Specialty that can be used as a source for your patient selection list.
5. Set My Preferred Team List/ Personal Patient List	This option lets you specify a default Team/Personal list for patient selection.
6. Set My Preferred Combination of Multiple Sources	This option lets you specify a patient list based on a combination of other default sources.
7. Set My Preferred Clinic Start Date	Patients with appointment dates as early as this date will be included in patient selection lists based on your preferred default clinic.
8. Set My Preferred Clinic Stop Date	Patients with appointment dates as recent as this date will be included in patient selection lists based on your preferred default clinic.
9. Set My Preferred Clinic Sunday	This option lets you specify the default clinic that will be used for Sundays when "Clinic" is your default patient selection list source.
10. Set My Preferred Clinic Monday	This option lets you specify the default clinic that will be used for Mondays when "Clinic" is your default patient selection list source.
11. Set My Preferred Clinic Tuesday	This option lets you specify the default clinic that will be used for Tuesdays when "Clinic" is your default patient selection list source.
12. Set My Preferred Clinic Wednesday	This option lets you specify the default clinic that will be used for Wednesdays when "Clinic" is your default patient selection list source.

	patient selection list source.
13. Set My Preferred Clinic Thursday	This option lets you specify the default clinic that will be used for Thursdays when "Clinic" is your default patient selection list source.
14. Set My Preferred Clinic Friday	This option lets you specify the default clinic that will be used for Fridays when "Clinic" is your default patient selection list source.
15. Set My Preferred Clinic Saturday	This option lets you specify the default clinic that will be used for Saturdays when "Clinic" is your default patient selection list source.
16. Set My Preferred Sort Order for Patient List	This option lets you specify the default sort order for your patient selection lists. Room/Bed is valid only for inpatients list (Ward, Team/Personal, Provider, Specialty). Appointment Date is valid only for outpatient lists (Clinic)
17. Display My Preferred Patient List Source	This option lets you display your current preferred default patient list source.

Set My Preferred List Source

Perform this option to specify your preferred default patient list source. Valid values for your preferred patient selection list source include:

T Team/Personal List

W Ward List

C Clinic List

P Provider List

S Specialty List

M Combination List

In the example screen capture that follows, M was selected to illustrate the new function of the Combination of Multiple Sources option.

```
   1      Set My Preferred List Source
   2      Set My Preferred Ward
   3      Set My Preferred Primary Provider
   4      Set My Preferred Treating Specialty
   5      Set My Preferred Team List/Personal Patient List
   6      Set My Preferred Combination of Multiple Sources
   7      Set My Preferred Clinic Start Date
   8      Set My Preferred Clinic Stop Date
   9      Set My Preferred Clinic Sunday
   10     Set My Preferred Clinic Monday
   11     Set My Preferred Clinic Tuesday
   12     Set My Preferred Clinic Wednesday
   13     Set My Preferred Clinic Thursday
   14     Set My Preferred Clinic Friday
   15     Set My Preferred Clinic Saturday
   16     Set My Preferred Sort Order for Patient List
   17     Display My Preferred Patient List Source

Select Patient Selection Preference Mgmt Option:  1


------------------- Setting   for User: NOWLING,SCOTT -------------------
Value: M  Combination List
```

Set My Preferred Combination of Multiple Sources

After selection "M" for the Preferred List Source, perform this option to select default Combination Patient List Sources.

```
   1      Set My Preferred List Source
   2      Set My Preferred Ward
   3      Set My Preferred Primary Provider
   4      Set My Preferred Treating Specialty
   5      Set My Preferred Team List/Personal Patient List
   6      Set My Preferred Combination of Multiple Sources
   7      Set My Preferred Clinic Start Date
   8      Set My Preferred Clinic Stop Date
   9      Set My Preferred Clinic Sunday
   10     Set My Preferred Clinic Monday
   11     Set My Preferred Clinic Tuesday
   12     Set My Preferred Clinic Wednesday
   13     Set My Preferred Clinic Thursday
   14     Set My Preferred Clinic Friday
   15     Set My Preferred Clinic Saturday
   16     Set My Preferred Sort Order for Patient List
   17     Display My Preferred Patient List Source

Select Patient Selection Preference Mgmt Option:  6


                          Set Default Combination
------------------------------------------------------------------------------

   Your current combination entries are:

No current combination entries....

-------------------- Setting for user: GREEN,JOANN ----------------------
Select COMBINATION ITEM:
```

View All Combination Options for a Particular Source Type

You may display all of the available choices for a particular source type by typing the list source prefix followed by a period and a single question mark.

Source Type	To display full list, type:
Ward	W.?
Provider	P.?
Specialty	S.?
Team List	T.?
Clinic	C.?

When CPRS asks for a combination item, type the first letter of the source type, followed by a period and then a question mark to view a list of all of the possible values in that source type. You may select as many choices as you desire. However, you may want to keep the number of sources reasonable to prevent the creation of an impractically large selection list.

```
-------------------- Setting for user: NOWLING,SCOTT --------------------
Select COMBINATION ITEM: CARDIOLOGY// W.?

     Searching for a WARD, (pointed-to by COMBINATION ITEM)


   Choose from:


     Searching for a WARD

    Answer with WARD LOCATION NAME, or SERVICE, or *NSERV, or SYNONYM
   Choose from:
   13A PSYCH
   1A
   2B MED
   8E REHAB MED
   8W
   DOM
   JLC TEST
   NOT 2B
   RICKS WARD
     ??
Select COMBINATION ITEM: CARDIOLOGY//
```

To View Combination Selections

To view existing combination selections, choose option 6 from the Patient Selection Preference Menu.

```
   1      Set My Preferred List Source
   2      Set My Preferred Ward
   3      Set My Preferred Primary Provider
   4      Set My Preferred Treating Specialty
   5      Set My Preferred Team List/Personal Patient List
   6      Set My Preferred Combination of Multiple Sources
   7      Set My Preferred Clinic Start Date
   8      Set My Preferred Clinic Stop Date
   9      Set My Preferred Clinic Sunday
   10     Set My Preferred Clinic Monday
   11     Set My Preferred Clinic Tuesday
   12     Set My Preferred Clinic Wednesday
   13     Set My Preferred Clinic Thursday
   14     Set My Preferred Clinic Friday
   15     Set My Preferred Clinic Saturday
   16     Set My Preferred Sort Order for Patient List
   17     Display My Preferred Patient List Source

Select Patient Selection Preference Mgmt Option:  6


                          Set Default Combination
------------------------------------------------------------------------------

   Your current combination entries are:

Clinic:     CARDIOLOGY
Provider:   NOWLING,SCOTT
Specialty:  SURGERY
Team List:  RED
Team List:  YELLOW

-------------------- Setting for user: NOWLING,SCOTT --------------------
Select COMBINATION ITEM: YELLOW//
```

To Add a Combination Selection

To add a new source to your combination list, type in the first letter of the Source Type followed by a period and then the source. There are two confirmation steps for adding a combination selection.

```
Select COMBINATION ITEM: CARDIOLOGY// T.YELLOW

     Searching for a TEAM LIST, (pointed-to by COMBINATION ITEM)


     Searching for a TEAM LIST
  YELLOW
        ...OK? Yes// Y  (Yes)
  Are you adding 'YELLOW' as a new COMBINATION ITEM (the 6TH for this
OE/RR PT SEL COMBO)? No// Y  (Yes)
Select COMBINATION ITEM:
```

To Remove a Combination Selection from Your List

To remove a source from your combination list, type in the name of the source that you want to delete and confirm it when prompted. With the combination item listed on the command line, type the "at" symbol (@) and press ENTER. Then confirm the deletion.

```
-------------------- Setting for user: GREEN,JOANN --------------------
Select COMBINATION ITEM: YELLOW// GOLD

     Searching for a WARD, (pointed-to by COMBINATION ITEM)


     Searching for a PROVIDER, (pointed-to by COMBINATION ITEM)


     Searching for a SPECIALTY, (pointed-to by COMBINATION ITEM)


     Searching for a TEAM LIST, (pointed-to by COMBINATION ITEM)
  GOLD
        ...OK? Yes// Y  (Yes)
  COMBINATION ITEM: GOLD// @
   SURE YOU WANT TO DELETE THE ENTIRE COMBINATION ITEM? Y  (Yes)
Select COMBINATION ITEM:
```

Tab Default Chart Preferences

This option provides an improved user interface for easy modification of CPRS tab default preferences in List Manager. Most of these defaults apply to both the GUI and List Manager versions of CPRS

Option	Description
Consults	This option lets you specify the default chart preferences for consults and includes settings for beginning date, ending date, status, service, and all.
Inpatient Labs	This option lets you specify the default chart preferences for inpatient labs and includes settings for beginning date, ending date, type, and all.
Outpatient Labs	This option lets you specify the default chart preferences for outpatient labs and includes settings for beginning date, ending date, type, and all.
Meds	This option lets you specify the default chart preferences for medications and includes settings for beginning date, ending date, whether outpatient or inpatient meds should be displayed, and all.
Notes	This option lets you specify the default chart preferences for notes and includes settings for beginning date, ending date, status, author, occurrence limit, subject, and all.
Orders	This option lets you specify the default chart preferences for orders and includes settings for beginning date, ending date, status, service/section, format, and all.
Problems	This option lets you specify the default chart preferences for problems and includes settings for status, comment, and all.
Reports	This option lets you specify the default chart preferences for Health Summaries and includes settings for beginning date, ending date, max, and all.
D/C Summaries	This option lets you specify the default chart preferences for discharge summaries and includes settings for beginning date, ending date, status, author, and all.
Imaging	This option lets you specify the default chart preferences for imaging and includes settings for beginning date, ending date, max, and all.

Example

```
Select Personal Preferences Option: TD  Tab Default Chart Preferences


         1    CONSULTS
         2    INPATIENT LABS
         3    OUTPATIENT LABS
         4    MEDS
         5    NOTES
         6    ORDERS
         7    PROBLEMS
         8    REPORTS
         9    D/C SUMMARIES
        10    IMAGING
     Select tab for preferences editing:  (1-10): 1


      1     BEG           Begin Date
      2     END           End Date
      3     STATUS        Status
      4     SERVICE       Service
      5     ALL           Edit All Above Items
   Select CONSULTS value to edit:  (1-5): 1


   Enter Begin Date value:  t-180//
   Enter End Date value:  t+90//
   Enter Status value:  t-180//
   Enter Service value:  t-180//
```

Glossary

CPRS	Computerized Patient Record System, the **VISTA** package (in both GUI and character-based formats) that provides access to most components of the patient chart.
AICS	Automated Information Collection System, formerly called Integrated Billing; software developed at Albany IRMFO, supported by MCCR, producing scannable Encounter Forms.
ASU	Authorization/Subscription Utility, a **V*IST*A** application (initially released with TIU) that allows VAMCs to assign privileges such as who can do what in ordering, signing, releasing orders, etc.
CAC	Clinical Applications Coordinator. The CAC is a person at a hospital or clinic assigned to coordinate the installation, maintenance and upgrading of CPRS and other VistA software programs for the end users.
Chart Contents	The various components of the Patient Record, equivalent to the major categories of a paper record; for example, Problem List, Progress Notes, Orders, Labs, Meds, Reports, etc. In CPRS, these components are listed at the bottom of the screen, to be selected individually for performing actions.
Consults	Consult/Request Tracking, a **V*IST*A** product that is also part of CPRS (it can function as part of CPRS, independently as a standalone package, or as part of TIU). It's used to request and track consultations or procedures from one clinician to another clinician or service.
Cover Sheet	A screen of the CPRS patient chart that displays an overview of the patient's record.
CWAD	Crises, Warnings, Allergies/Adverse Reactions, and Directives. These are displayed on the Cover Sheet of a patient's computerized record, and can be edited, displayed in greater detail, or added to. *See Patient Postings.*
D/C Summary	Discharge Summary; see below.
Discharge Summary	A component of TIU that can function as part of CPRS, Discharge Summaries are recapitulations of a patient's course of care while in the hospital.
GAF	Global Assessment of Functioning is a rating of overall psychological functioning on a scale of 0 – 100. The GAF tab is available in the CPRS GUI in VA Mental Health facilities.
GUI	Graphical User Interface—a Windows-like screen with pull-down menus, icons, pointer device, etc.
Health Summary	A **V*IST*A** product that can be viewed through CPRS, Health Summaries are components of patient information extracted from other **V*IST*A** applications.
Imaging	A **V*IST*A** product that is also a component of CPRS; it includes Radiology, X-rays, Nuclear Medicine, etc.

Notifications	Alerts regarding specific patients that appear on the CPRS patient chart. They can be responded to through "VA View Alerts."
OE/RR	Order Entry/Results Reporting, a **V*IST*A** product that evolved into the more comprehensive CPRS.
Order Checking	A component of CPRS that reviews orders as they are placed to see if they meet certain defined criteria that might cause the clinician placing the order to change or cancel the order (e.g., duplicate orders, drug-drug/diet/lab test interactions, etc.).
Order Sets	Order Sets are collections of related orders or Quick Orders, (such as Admission Orders or Pre-Op Orders).
PCE	Patient Care Encounter, a VistA program that is part of the Ambulatory Data Capture Project (ADCP) and also provides Clinical Reminders, which appear on Health summaries.
PCMM	Patient Care Management Module, a **V*IST*A** product that manages patient/provider lists.
Patient Postings	A component of CPRS that includes messages about patients; an expanded version of CWAD (see above).
Progress Notes	A component of TIU that can function as part of CPRS.
Quick Orders	Quick Orders allow you to enter many kinds of orders without going through as many steps. They are types of orders that physicians have determined to be their most commonly ordered items and that have standard collection times, routes, and other conditions.
Reports	A component of CPRS that includes Health Summary, Action Profile, and other summarized reports of patient care.
TIU	Text Integration Utilities; a package for document handling, that includes Consults, Discharge Summary, and Progress Notes, and will later add other document types such as surgical pathology reports. TIU components can be accessed for individual patients through the CPRS, or for multiple patients through the TIU interface.
VISN	Veterans Information System Network, the regional organizations for managing computerization within a region.
V*IST*A	Veterans Information Systems Technology Architecture, the new name for DHCP.

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